CNA

Aging Services Professional Liability Claim Report: 12th Edition

CNA and I wish to thank you for dedicating time to review this report, learn from the findings, and implement actions that will advance the industry to a better tomorrow. We have once again collaborated to deliver to you one of the aging services industry's most comprehensive analysis of professional liability claims.

With more than 50 years of experience, CNA remains an industry leader in providing insurance solutions for professional liability exposures encountered by those individuals serving the aging services industry. We have leveraged our extensive experience by analyzing our closed claims data to raise awareness of those circumstances that occur most frequently and result in harm to residents. We strive to provide the relevant facts influencing the industry, as well as endeavor to minimize speculation.

This report provides information during a period with unique circumstances surrounding the claims management process. This period includes the pandemic era with court closures and claims incurred under unusual and uncertain happenings. I urge caution not to utilize this report to predict future claim trends based upon this short-term dataset that was affected by these pandemic circumstances. A review of long-term data implies a higher severity trend than the changes in average total incurred within the findings of this report.

My sincere hope is that you share our passion for delivering quality experiences to seniors and leverage the insights gained from this resource to assist you in doing so. I wish for you to ask yourselves challenging questions about these insights, such as "In an era of advanced technological innovation and risk management emphasis on core loss drivers, why is the industry not realizing improvement in claim severity trends, and what can be done to create change for the better?"

Blaine Thomas
CNA Vice President, Underwriting – Aging Services

Top Ten Key Findings

The **distribution of claims by bed type has remained stable** when compared to prior CNA Aging Services Professional Liability Claim Reports. (Page 6)

While the **severity of claims has increased** across all bed types, **assisted living facilities** have experienced the **largest increase of 7.6 percent**, from $267,174 in the 2021 dataset to $287,597 in the 2024 dataset. (Page 6)

The **gap has continued to widen in severity** between assisted living facilities and skilled nursing facilities, with the **average total incurred for assisted living facilities** now **14.4 percent higher** than that of skilled nursing facilities in the 2024 dataset. (Page 6)

The **overall average total incurred** for all facilities has **increased 3.8 percent** from $250,048 in the 2021 dataset to $259,443 in the 2024 dataset. (Page 6)

Resident falls and pressure injuries account for **63.2 percent** of all closed claims. (Page 9)

Allegations of **failure to move a resident to a higher level of care**, representing only 0.8 percent of claims, experienced **a significant increase in severity** – up from $233,602 in the 2021 dataset to $312,107 in the 2024 dataset. (Page 10)

Assisted living facilities continue to have a **higher portion of resident falls and elopement claims** and a lower incidence of pressure injury claims than skilled nursing facilities. (Page 11)

The **average total incurred of resident abuse claims** in skilled nursing facilities has **increased by 45.7 percent** since the 2021 dataset ($257,524 to $375,338), with the **assisted living average** total incurred **increasing by 17.3 percent** ($337,892 to $396,263). (Page 19)

While **elopement claims** are limited in frequency, these claims continue to be a **source of financial and reputational harm** for aging services organizations, with an **average total incurred of $303,883** in the 2024 dataset. (Page 22)

While the frequency of **medication errors** resulting in resident harm is relatively low, these errors have the **potential to cause significant injuries to residents** resulting in claims with high severity, with an **average total incurred of $306,373** in the 2024 dataset. (Page 25)

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Part 1: Dataset Overview

Dataset and Methodology

The analysis in this report is based on aging services professional liability claims that closed between January 1, 2021, and December 31, 2023. These claims will be referenced as the "2024 dataset" throughout the report. It should be noted that closed claims are historical by nature. As claims often take years to develop, this retrospective examination of closed claims does not reflect the value of current or future claims. Closed claims with an indemnity payment of less than $10,000 were excluded, as were claims from adult day care programs and home healthcare providers insured within this period of time. Please note that percentages in charts or graphs may not add up to exactly 100 percent due to rounding or excluding categories that are immaterial to the analysis.

Limitations and Considerations

- The dataset is exclusively comprised of aging services organizations insured by CNA and does not take into consideration any additional data sources.
- Indemnity and expense payments include only monies paid by CNA on behalf of its insureds.
- Deductibles are not included, nor are other sources of payment in response to the claim.
- The data reflect the $1 million per claim limit typical of CNA primary professional liability insurance policies.
- The data include those closed claims with a minimum indemnity payment of $10,000.
- Inclusion in this dataset is based upon the year a claim closed, irrespective of when the incident occurred.
- Caution should be taken when comparing findings with previously published CNA reports or industry publications due to potential differences in inclusion criteria.

Terms

For the purposes of this report only, please refer to the following terms and explanations.

- **Average total incurred** and **paid severity** refers to indemnity plus expense costs paid by CNA, divided by the number of related closed claims included in the dataset.
- **Bed type** refers to the level of service (e.g., independent living, assisted living or skilled nursing) provided at the time of the incident based upon the resident contract, as well as the policies and procedures or protocols established by the aging services organization.
- **Distribution** refers to a specific group of closed claims with categories expressed as a percentage of the total.
- **Expenses** are monies paid by CNA for the investigation, management and/or defense of a claim or lawsuit.
- **Improper care** refers to failure to follow an established nursing care/service plan, reasonable standard of care, or organizational policy and procedure.
- **Incurred claims** are those reported claims that result in an indemnity and/or expense payment.
- **Indemnity payments** are monies paid by CNA for the settlement, arbitration award or judgment of a claim.

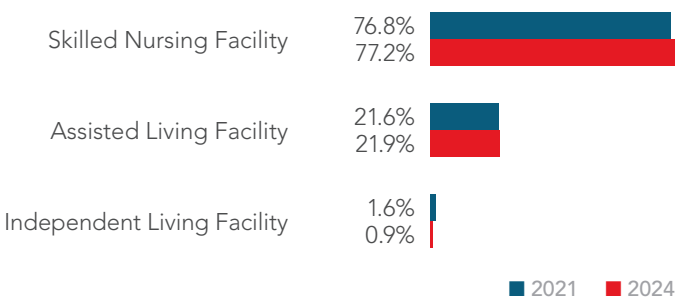
Part 2: Closed Claim Analysis

Analysis of Claim Trends by Bed Type

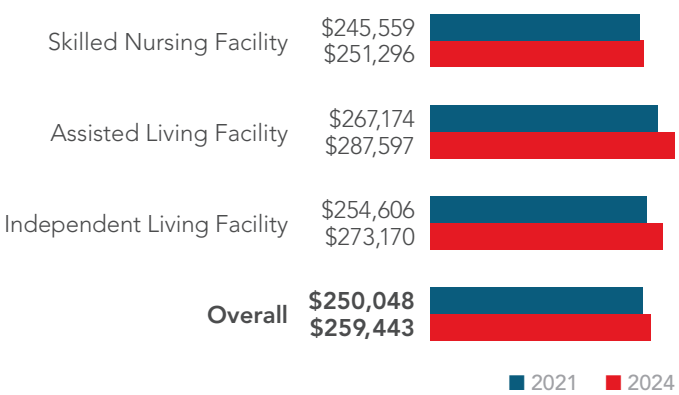
In general, the distribution of claims by bed type has remained stable when compared to prior CNA Aging Services Professional Liability Claim Reports, as indicated in **Figure 1**. However, the overall average total incurred for all facility types, as demonstrated by **Figure 2**, has increased 3.8 percent – from $250,048 in the 2021 dataset to $259,443 in the 2024 dataset. While the severity of claims has increased across all bed types, assisted living facilities have experienced the largest increase of 7.6 percent, from $267,174 in the 2021 dataset to $287,597 in the 2024 dataset. This increase has continued to widen the gap in severity between assisted living and skilled nursing facilities, with the average total incurred for assisted living facilities now 14.4 percent higher than that of skilled nursing facilities in the 2024 dataset.

The **distribution of claims by bed type has remained stable** when compared to prior CNA Aging Services Professional Liability Claim Reports.

1 Distribution of Closed Claims by Bed Type
Closed Claims with Paid Indemnity of ≥ $10,000



2 Average Total Incurred by Bed Type
Closed Claims with Paid Indemnity of ≥ $10,000



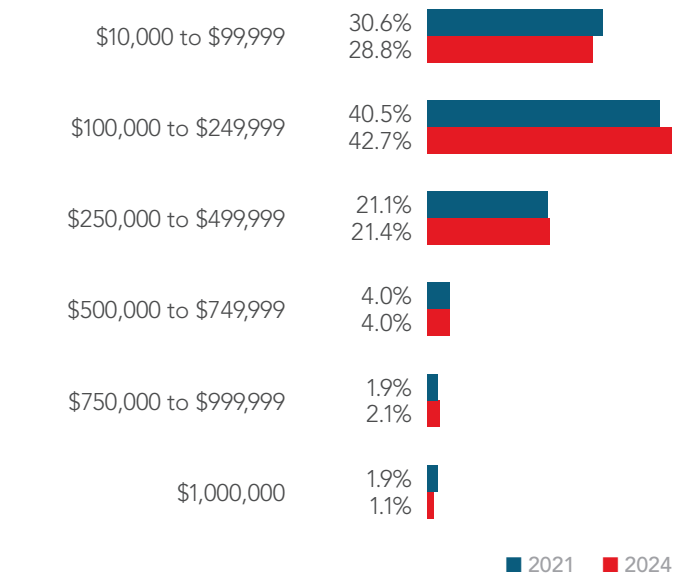
While the **severity of claims has increased** across all bed types, **assisted living facilities** have experienced the **largest increase of 7.6 percent**, from $267,174 in the 2021 dataset to $287,597 in the 2024 dataset.

Contributing to the increase in severity is a larger proportion of claims settling with indemnity amounts between $100,000 and $499,999 and a decrease in claims settling for less than $99,999, as depicted in **Figure 3**. Although this increase in claim severity is likely influenced by numerous factors related to the underlying circumstances of each case, it is also important to consider the impact of industry trends such as social inflation.

The **gap has continued to widen in severity** between assisted living facilities and skilled nursing facilities, with the **average total incurred for assisted living facilities** now **14.4 percent higher** than that of skilled nursing facilities in the 2024 dataset.

3 Distribution of Closed Claims by Paid Indemnity Range

Closed Claims with Paid Indemnity of ≥ $10,000



How Courts Define Malpractice

Four elements must exist for an incident to be considered malpractice:

Duty
A provider-resident relationship must exist.

Breach
Standard of care was not met.

Harm
Injury resulted in damages.

Causation
Injury was caused by the provider's error.

Top 5 Highest Severity Allegations

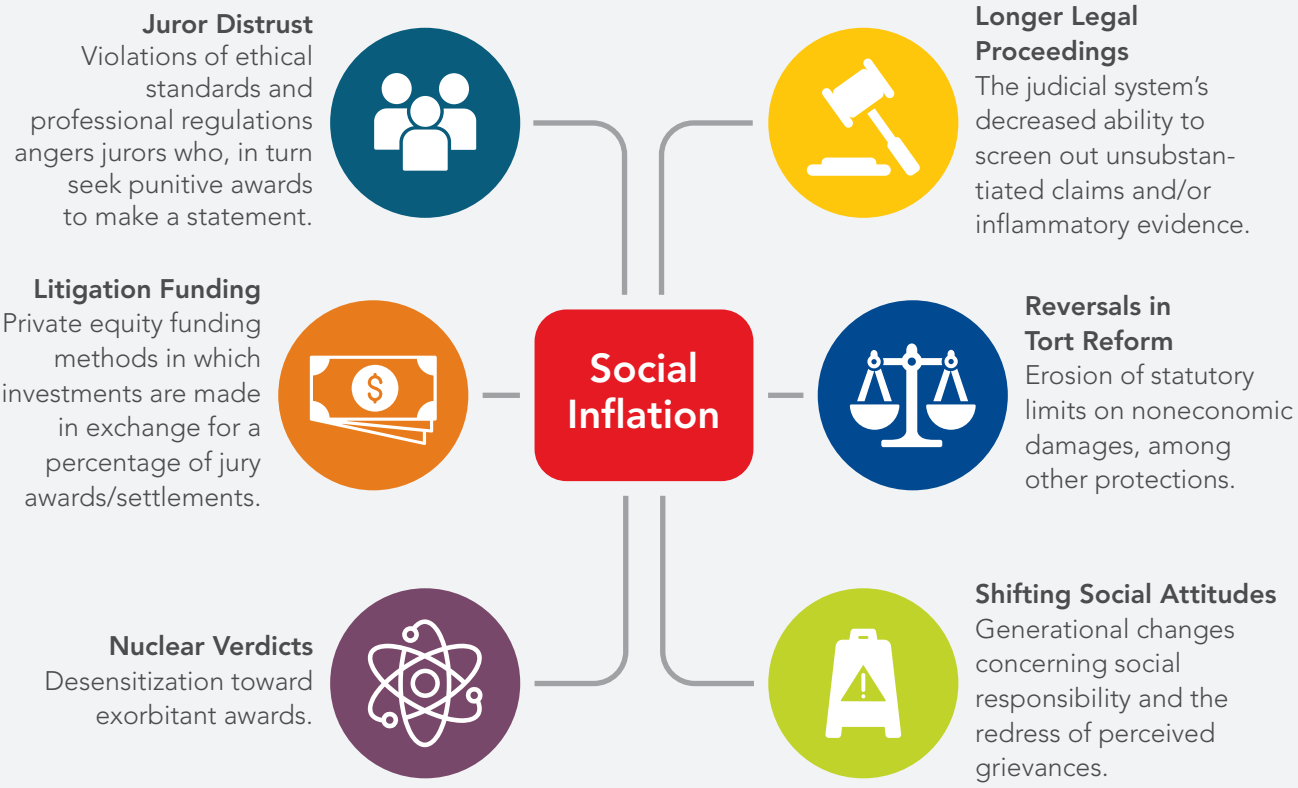
1. **$384,088** Resident abuse
2. **$312,107** Failure to move resident to higher level of care
3. **$311,480** Failure to follow physician's order
4. **$306,373** Medication error
5. **$303,883** Elopement

Impact of Social Inflation

The cost of liability claims in the United States continues to outpace the rate of general inflation by at least 10 percent. The difference between the increase in costs associated with professional liability claims resolution and the inflation rate is known as "social inflation" or "tort inflation." This is a reference to the underlying political and cultural factors that influence the legal system. Left unchecked, social inflation may result in rising premiums, diminishing coverage capacity and underfunded loss drivers. It also increases healthcare costs and may result in bankruptcies and the closure of some healthcare facilities.

The current escalation in indemnity payments reflects a tendency toward plaintiff-friendly judgments by juries and the proliferation of so-called "nuclear verdicts" (damage awards in the tens and even hundreds of millions of dollars). More information on social inflation can be found in the 2024 CNA *AlertBulletin*® entitled "Social Inflation: Understanding and Addressing Rising Claim Costs."

Social Inflation



The **overall average total incurred** for all facilities has **increased 3.8 percent** from $250,048 in the 2021 dataset to $259,443 in the 2024 dataset.

Analysis of Allegations

It should be noted that the fluctuating severity for independent living facilities reflects the volatility caused by a small number of claims and does not represent a trend. While independent living facilities do incur professional liability claims, the majority of claims in the 2024 dataset occurred in the skilled and assisted living environments. Therefore, the remainder of the report will focus on exposures in these two facility types.

Claims asserted against aging services facilities may arise from a myriad of risks related to care needs, staffing levels, abuse, elopement and environmental hazards, amongst others.

Common challenges prevalent among the aging population, such as chronic illness, mobility limitations, and cognitive impairments can significantly elevate the vulnerability of residents to medical emergencies and adverse events. Furthermore, inadequate staffing levels may compromise the quality of care and supervision, potentially resulting in allegations of neglect or care that falls below the standard of care. Environmental hazards such as slippery floors, poor lighting, and improper furniture placement heighten the risk of falls and injuries.

Figure 4 indicates that there have been no significant changes in the distribution of the top allegations, with resident falls and pressure injuries accounting for 63.2 percent of all closed claims. Falls and pressure injuries also experienced similar increases in severity of 4.8 percent – with the average total incurred increasing from $228,251 to $239,276 for falls and $254,108 to $266,183 for pressure injuries, as seen in **Figure 5**.

Resident falls and pressure injuries account for **63.2 percent** of all closed claims.

Key Risk Management Principles

- ☐ Appropriate Communication
- ☐ Thorough Documentation
- ☐ Effective Adverse Event Management
- ☐ Detailed Treatment and Referral Process
- ☐ Thorough Resident Assessment
- ☐ Comprehensive Care/Service Plan
- ☐ Realistic Expectation Setting

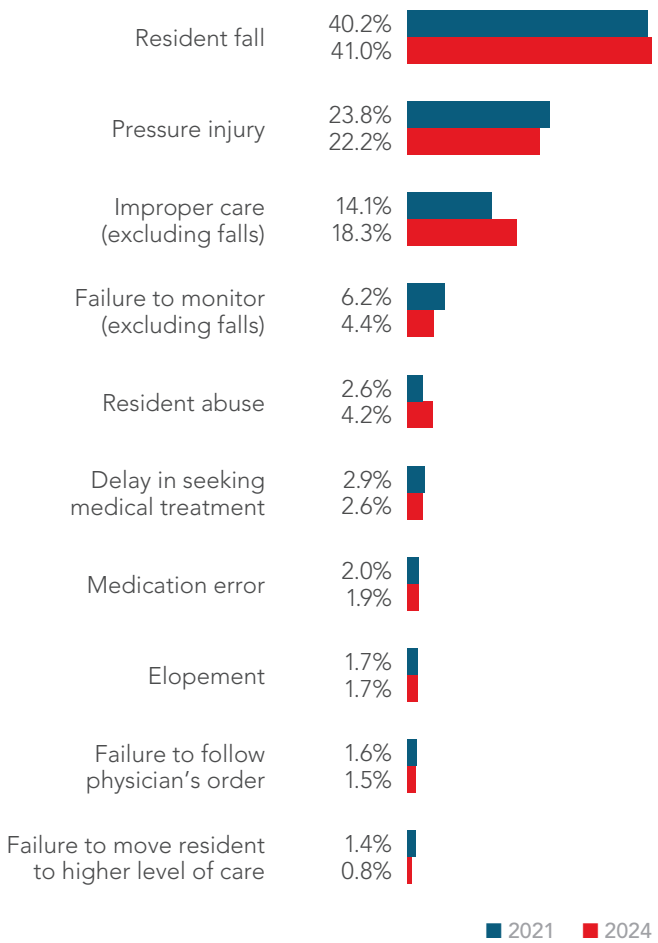
Claims related to resident abuse have increased from 2.6 percent of the distribution of closed claims in the 2021 dataset to 4.2 percent of the 2024 dataset, as shown in **Figure 4**. Claims related to resident abuse also represent one of the largest increases in severity at 26.7 percent, with an average total incurred of $303,251 in the 2021 dataset as compared to $384,088 in the 2024 dataset, as seen in **Figure 5**.

- Medication errors represent 1.9 percent of the claims; however, severity has increased since the prior report ($278,826 to $306,373).
- Similarly, allegations of failure to move a resident to a higher level of care, representing only 0.8 percent of claims, experienced a significant increase in severity, up 33.6 percent from $233,602 in the 2021 dataset to $312,107 in the 2024 dataset.

Allegations of **failure to move a resident to a higher level of care**, representing only 0.8 percent of claims, experienced **a significant increase in severity** – up from $233,602 in the 2021 dataset to $312,107 in the 2024 dataset.

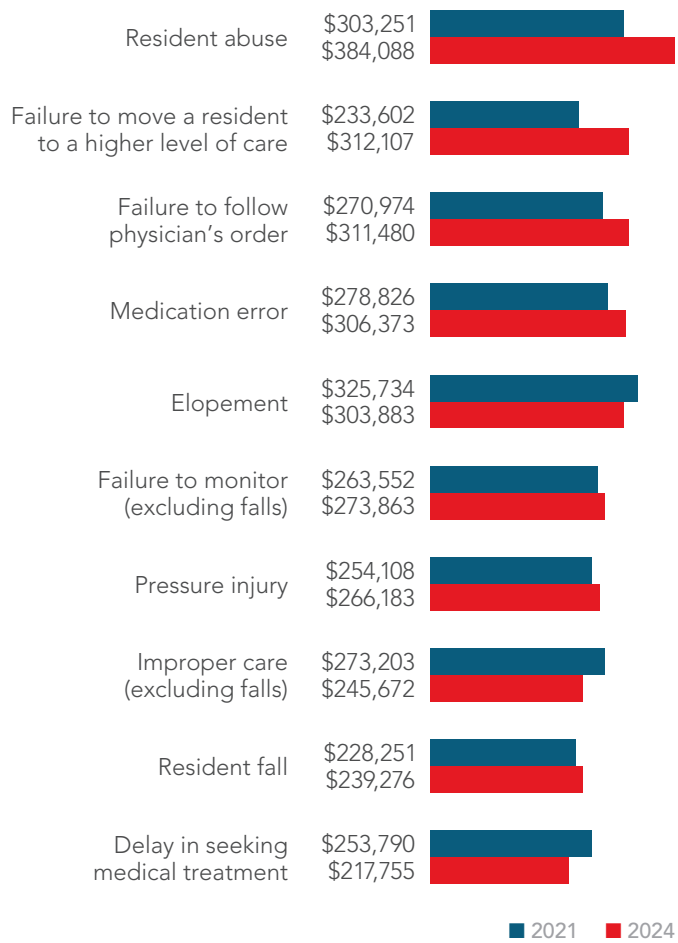
4 Distribution of Closed Claims by Top 10 Allegations

Closed Claims with Paid Indemnity of ≥ $10,000



5 Average Total Incurred by Top 10 Allegations

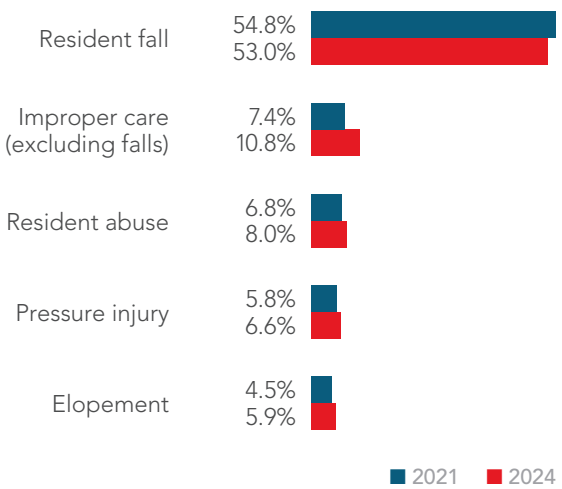
Closed Claims with Paid Indemnity of ≥ $10,000



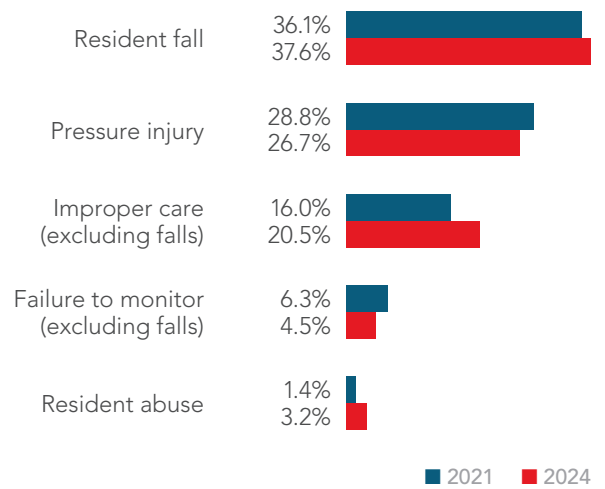
Allegations by Setting: Comparison of Assisted Living Facilities and Skilled Nursing Facilities

- Due to the increased mobility of residents, assisted living facilities continue to have a higher portion of resident falls and elopement claims and a lower incidence of pressure injury claims than skilled nursing facilities, as evidenced by comparing **Figure 6** and **Figure 7**.
- Resident falls are the most frequent allegation in assisted living facilities at 53.0 percent. Residents may be more mobile and require less supervision than in a skilled nursing facility, leading to increased frequency of falls. Staffing levels in assisted living facilities are lower than skilled nursing facilities, with less frequent opportunities to observe residents in their apartments and other locations within the facility.

6 **Top 5 Allegations – Assisted Living**
Closed Claims with Paid Indemnity of ≥ $10,000



7 **Top 5 Allegations – Skilled Nursing**
Closed Claims with Paid Indemnity of ≥ $10,000



Assisted living facilities continue to have a **higher portion of resident falls and elopement claims** and a lower incidence of pressure injury claims than skilled nursing facilities.

Falls Facts – Older Adults

One out of every five falls results in a serious injury such as broken bones or a head injury.

Each year, three million older people are treated in emergency departments for injuries related to falls.

Annually, at least 300,000 older people are hospitalized for hip fractures.

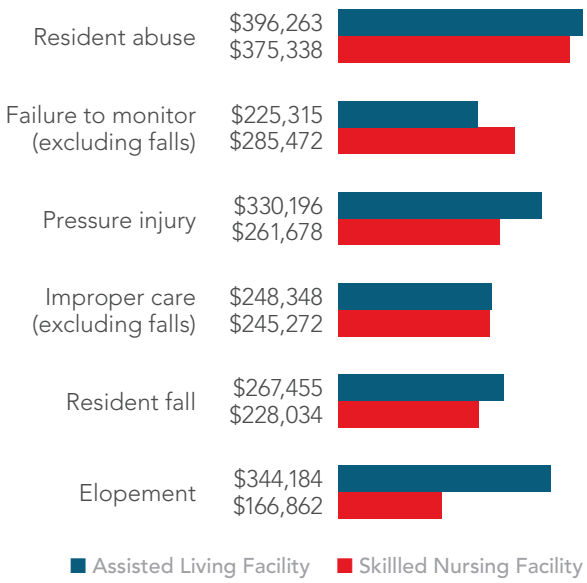
Falls are the most common cause of traumatic brain injuries (TBI).

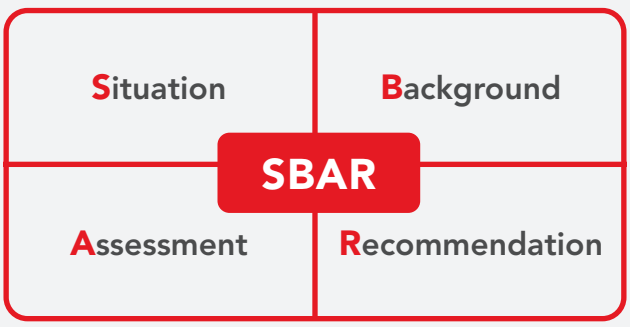
For more information see the CDC's "Facts About Falls."

- Resident abuse claims have increased in frequency for both assisted living facilities and skilled nursing facilities and have the highest severity across the top allegations with an average total incurred of $396,263 and $375,338 for assisted living facilities and skilled nursing facilities, as seen in **Figure 8**. Complicated resident-family dynamics, staffing challenges, complex care needs, and lack of effective abuse training can increase the likelihood of an allegation of abuse.
- Assisted living facilities with residents who require a higher level of care may be contributing to the increase in improper care allegations. Improper care allegations include a failure to notify a provider of a change in condition, communication failures between care providers and delays in treatment, amongst others.

8 **Average Total Incurred for Top Allegations by Bed Type**

Closed Claims with Paid Indemnity of ≥ $10,000





SBAR is a simple, structured tool for framing conversations, especially urgent ones needing immediate clinical attention. It sets clear expectations for communication among team members, promoting teamwork and resident safety.

Residents who require a higher level of care may be **contributing** to the **increase in improper care allegations**. Improper care allegations include a **failure to notify a provider** of a change in condition, **communication failures** between care providers and **delays in treatment**, amongst others.

Part 3: Risk Control Focus

Resident safety and risk mitigation can be enhanced by establishing a culture of safety in assisted living and skilled nursing facilities. This philosophy includes the practice of continuous monitoring, tracking, evaluating systems and using feedback to improve processes and outcomes.

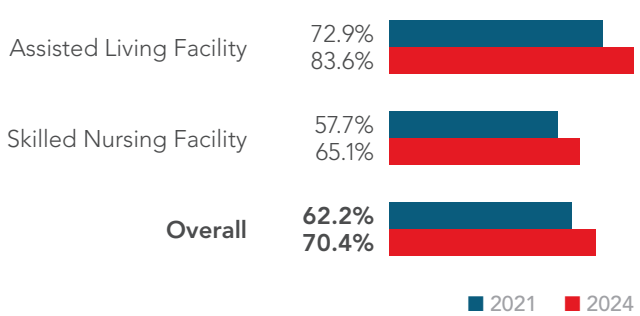
Falls

Resident falls remain the most frequent allegation in both skilled nursing facilities (37.6 percent) and assisted living facilities (53.0 percent), as previously noted in **Figures 6 and 7**. Aging services residents have numerous conditions that may make them more susceptible to falls, including reduced mobility, balance issues, hearing loss and cognitive impairments, amongst others. Additionally, staffing shortages and inadequate training of staff in fall prevention techniques and protocols also contribute to the prevalence of fall-related claims.

- Within assisted living and skilled nursing facilities, the number of falls associated with residents with a dementia diagnosis increased from 62.2 percent in the 2021 dataset to 70.4 percent in the 2024 dataset, as seen in **Figure 9**.
- The overall average total incurred for fall claims involving residents with dementia has increased to $246,481 in the 2024 dataset as compared to $231,951 in the 2021 dataset, as noted in **Figure 10**.
- Residents with dementia have altered awareness of their surroundings, along with impaired balance that could contribute to more frequent falls. Even minor fall-related injuries can lead to hospitalization, the subsequent need for a higher and more costly level of care post fall, and possibly lead to claims. In addition, residents with dementia may not accurately recall the circumstances of the fall and/or any related injuries, resulting in a delay to seek treatment or implement fall prevention care plan changes.

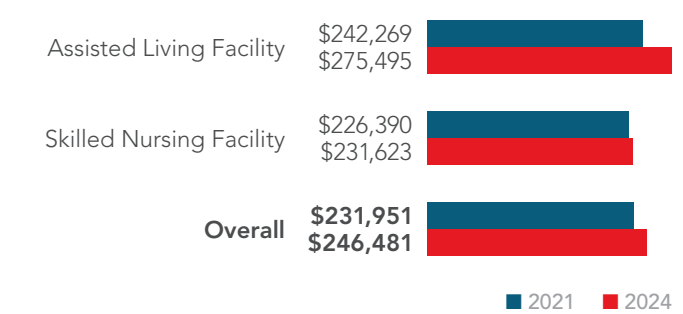
9 Distribution of Fall Claims Involving Residents with Dementia

Closed Claims with Paid Indemnity of ≥ $10,000



10 Average Total Incurred of Fall Claims Involving Residents with Dementia

Closed Claims with Paid Indemnity of ≥ $10,000



Not only do **falls potentially cause resident harm**, but they can also present **reputational**, and, in some cases, **financial harm**.

Claims involving resident falls can present challenges in defensibility, as highlighted in the following scenario:

An 80-year-old male was admitted to an assisted living facility with a diagnosis of mild dementia. He frequently skipped breakfast, as he preferred to sleep later. However, he would come to the community dining room for later meals.

Several weeks following his admission, his daughter arrived to find him lying next to his bed in a pool of urine. She had to search for his call button and would later testify that it was not within his reach. The resident sustained multiple contusions, swelling to his face and a large abrasion on his forehead. He was transferred to the emergency department, where he was admitted for an extended hospitalization. During his hospitalization, he was treated for rhabdomyolysis, presumably caused by the extended period he laid immobile on the floor of his room. This condition resulted in the permanent inability to walk, as well as a severe cognitive and emotional decline, requiring placement in a skilled nursing facility.

His family initiated litigation, alleging that the facility failed to conduct well-being checks and provide easy access to the emergency call button as explained to them during the move-in process. The family also alleged that the assisted living facility failed to perform adequate fall assessments and to implement adequate fall prevention measures. The resident's healthcare information record lacked documentation that he had been checked between the time he went to sleep the evening prior, to the time the family found him lying on the floor the next afternoon. The case was settled in mediation for $475,000.

Not only do falls potentially cause resident harm, but they can also present reputational, and, in some cases, severe financial harm. The claim below describes how equipment, such as assistive lift devices, and staff transfer techniques can be contributing factors in fall-related claims:

An 81-year-old male resident of a skilled nursing facility required full assistance with his activities of daily living (ADLs) and mechanical transfer to his wheelchair due to mobility issues and also required anti-coagulant therapy for other co-morbid conditions. He used his call bell to ask for assistance to transfer into his wheelchair. The certified nursing assistant responded and became impatient when no other qualified team members were available to assist her. She proceeded to utilize the mechanical lift to transfer the resident to his wheelchair, despite his documented care plan with an order for a two-person transfer. During the transfer from the bed to the wheelchair, the resident fell to the floor and complained of discomfort in both legs. The staff called the primary care physician several times without response. Documentation in the healthcare information record confirmed that the staff had encouraged the resident to go to the emergency department following the fall, but he refused. As the night progressed, the resident's legs became swollen, and his pain intensified. The following morning, the staff reached out to the medical director of the facility who advised that the resident should be transferred to the emergency department immediately. In the emergency department, x-rays revealed bilateral tibial fractures. During hospitalization, his condition deteriorated rapidly. He experienced "coffee ground" vomiting consistent with GI bleeding, bleeding in the intercompartmental fracture areas and the onset of renal failure. The resident died a few days following admission to the hospital.

The family initiated a lawsuit. In deposition, the certified nursing assistant noted that she operated the mechanical lift alone because the facility was short-staffed. The incident report prepared on the event date stated that there was no apparent injury following the fall. Defendants were criticized for their delay in transferring the resident to a higher level of care and for non-compliance with the care plan requirement for a two-person transfer. The case eventually settled for primary policy limits.

These types of claims demonstrate that resident falls remain a persistent challenge for aging services organizations. Aging services organizations must institute a strategic, proactive approach to mitigate fall risk exposures.

Fall Risk Management Recommendations

- **Fall Risk Assessment/Evaluation and Intervention:** Perform and record fall risk assessments/evaluations upon admission, quarterly, post-fall, and with a change in condition. Review fall risk at daily meetings including a review of the incident, healthcare information record, and care/service plan, as well as the effectiveness of interventions. Include fall trends, Centers for Medicare & Medicaid Services (CMS) measures when relevant, and performance improvement plans during quality assurance/performance improvement meetings.
- **Care/Service Planning:** Ensure that interdisciplinary care/service plans are reviewed, updated, and followed. Update and comply with care/service plan directives regarding fall risk and interventions. Ensure that staff are familiar with the risks associated with falls for residents undergoing anticoagulation therapy. Fall precautions should be documented in the care/service plan, and post-fall evaluations should be detailed in the healthcare information record. Document care/service conference participation of family and residents.
- **Documentation:** Document resident and family teaching. If the resident refuses to follow recommendations, the refusal should be noted in the healthcare information record, with notation that the resident and/or family/guardian were advised of the potential consequences of his/her decision. Whenever possible, a written refusal form, signed by the resident (who has capacity to understand and sign) and/or family/guardian or documented Power of Attorney, should be included in the healthcare information record. Reinforce clinical documentation practices through ongoing education, training, and peer review auditing.
- **Communication:** Create a work environment that initiates team huddles when a resident's clinical change in condition warrants further assessment and evaluation. Communicate with providers and families when there is an incident or change in condition. Avoid delays in care and transfers to higher levels of care when clinical change in condition indicates the need.
- **Expectations Management:** Educate staff on communication strategies aimed at eliciting, acknowledging, and managing realistic resident and family expectations, including fall management.
- **Training and Education:** Implement competency-based training on safe resident handling, including safe use of mechanical lifts upon hire, following related incidents and at least annually thereafter.
- **Incident Reporting and Investigation:** Ensure that incident reports are completed on a timely basis (e.g., by the end of the work shift), contain objective and factual information, and are reviewed by leadership for adequacy and compliance with the facility's incident reporting policy. Promptly investigate and conduct a root cause analysis, and, based upon findings, construct action plans. Incident data should be tracked, trended, analyzed and monitored to determine outcomes of interventions.

Spotlight on Falls

For additional risk mitigation strategies related to falls, access the CNA *CareFully Speaking*® publication entitled "Resident Falls: A Collaborative Strategy for Risk Mitigation."

Pressure Injuries

Allegations related to pressure injuries continue to be a frequent cause of claims within aging services facilities, as seen in **Figure 11**, due to the vulnerability of residents who often have limited mobility or underlying health conditions affecting skin integrity. Severity remains high with an average total incurred of $261,678 for skilled nursing facilities in the 2024 data-set and $330,196 for assisted living facilities, as seen in **Figure 12**. The increasing service needs of residents in assisted living facilities, coupled with the trend of co-management with home healthcare and hospice services, further heighten the risk of pressure injuries in this setting.

A skin integrity program and timely, documented interventions for residents at risk may decrease the frequency and mitigate the severity of pressure injuries. Staff education on proper care techniques and the use of risk assessment tools can help identify residents most vulnerable to injury. These strategies not only help improve resident outcomes, but they also reduce liability for facilities by demonstrating proactive efforts to prevent these serious and often avoidable injuries. The following case scenarios offer valuable insight into common failures that become challenges to defending these cases during the litigation process.

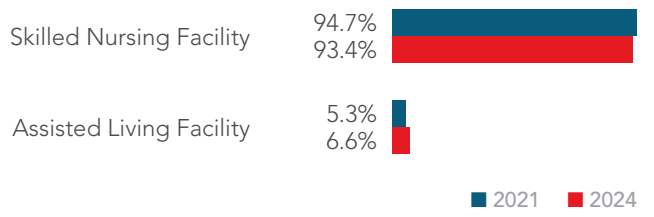
A 75-year-old male resident was admitted to a skilled nursing facility with a history of stroke and limited mobility. Despite being identified as high risk for pressure injuries upon admission, the facility failed to implement evidence-based prevention methods. The resident's care plan did not include regular repositioning, the use of specialized support surfaces, or adequate skin assessments.

The resident developed a stage 4 pressure injury on his coccyx, extending into muscle and bone, with associated infection. Despite the wound being visible and malodorous, there was no documented evidence that the nursing staff identified the injury in a timely manner or that the physician was notified. The resident experienced significant pain and discomfort, negatively affecting his overall health and quality of life.

The facility's failure to implement evidence-based prevention methods and to conduct regular nursing assessments challenged the defense of the claim. This case emphasizes the importance of adhering to established protocols and guidelines to prevent negative outcomes in at-risk residents. The total incurred for this case was more than $2 million.

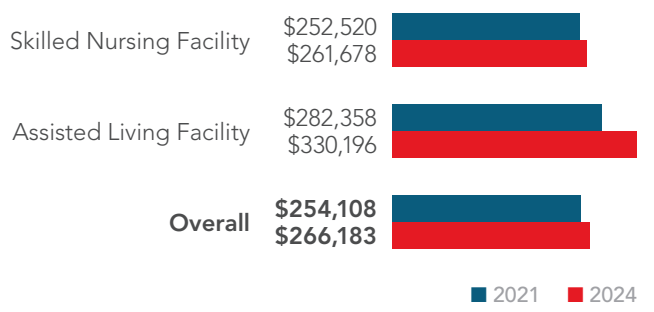
11 Distribution of Pressure Injury Claims by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



12 Average Total Incurred of Pressure Injury Claims by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



Spotlight on Pressure Injury Prevention

For more risk control strategies related to pressure injuries, access the CNA Special Resource "Pressure Injuries: Prevention and Intervention Strategies."

This case scenario further demonstrates the importance of documented assessments and timely interventions.

> *An 85-year-old assisted living resident had a history of hypertension and diabetes. The resident required assistance with mobility and transfers. On admission, the resident was assessed as being at high risk for pressure injuries due to his limited mobility and comorbidities.*
>
> *Over the course of several weeks, the resident's family noticed that he was becoming increasingly uncomfortable during visits. They observed him frequently shifting in his chair and notified staff of their concerns. The resident's provider ordered home health-care services to evaluate the resident's developing skin injury on his left hip. Despite the resident being assessed to be at high risk for pressure injuries, discovery of the newly identified skin injury and the family's concerns, the assisted living staff did not consistently implement or document preventive measures to reduce the likelihood of pressure injury progression. The facility also failed to ensure home healthcare services were initiated in a timely manner, resulting in a two-week delay in pressure injury treatment. The resident's left hip pain continued to worsen, and he was diagnosed with a stage 4 pressure injury. The wound was malodorous and evidenced signs of infection. Despite aggressive wound care treatments, including surgical debridement and IV antibiotics, the resident's pressure injury did not heal completely. He developed frequent infections and experienced a decline in his overall health. The resident eventually succumbed to sepsis secondary to the pressure injury. The case settled, following mediation, for $700,000.*

The importance of implementing comprehensive and proactive preventive measures for pressure injuries in high-risk residents cannot be overlooked. The combination of preventive measures and effective communication practices is essential for providing high-quality care to residents at risk of pressure injuries, helping to prevent adverse outcomes and improve overall resident well-being.

Pressure Injury Risk Management Recommendations

- **Regular Skin Assessment/Evaluation and Intervention:** Perform comprehensive skin assessments/evaluations upon admission and regularly thereafter to identify any changes or areas of concern. To enhance timely identification, multiple strategies should be employed to rapidly identify changes in a resident's skin health. Utilize standardized risk assessment/evaluation tools to identify residents at higher risk for pressure injuries and tailor prevention strategies accordingly.
- **Care/Service Planning:** Ensure that interdisciplinary care/service plans are reviewed, updated, and monitored for staff compliance with the plan and implementation of associated interventions. Pressure injury interventions should be documented in the care/service plan. Document care/service conference participation of family members and residents. Implement a schedule for repositioning residents at risk for pressure injuries to relieve pressure on bony prominences. This may include turning residents every two hours or using specialized beds that automatically reposition. Ensure consistent documentation of this intervention. Use specialized mattresses, cushions, or pads to redistribute pressure and reduce the risk of pressure injuries. These surfaces should be selected based upon the resident's individual risk and needs. Ensure residents receive adequate nutrition and hydration to support skin health and wound healing, in coordination with a registered dietician. Implement a skincare regimen that includes gentle cleansing, moisturizing, and protecting the skin from excess moisture or friction.

- **Documentation:** Effective documentation in pressure injury lawsuits is paramount for aging services providers and facilities, as it serves as an important means of demonstrating the quality of care provided. Thorough, accurate and timely documentation can help establish that healthcare providers followed established protocols, implemented evidence-based practices, and acted in the best interest of the resident. Additionally, comprehensive documentation can help defend against allegations of negligence or inadequate care by providing a clear record of the assessments/evaluations made, interventions implemented, and the resident's response to treatment. In legal proceedings, comprehensive documentation can be a powerful defense tool, highlighting the facility's commitment to providing quality care and adherence to professional guidelines. This includes noting the location, size, stage, and characteristics of the pressure injury. Use objective and descriptive language in documentation to help paint a clear picture of the resident's condition and the care provided. Document planned follow-up care after discharge or transfer to another facility, to ensure continuity of care and help prevent recurrence or worsening of pressure injuries. This documentation also serves as a record of pressure injury status upon leaving the facility and can be beneficial in determining progression of an injury in a subsequent care setting.
- **Wound Photography:** For aging services organizations that elect to photograph wounds, high-resolution digital cameras and specialized software enable staff to easily take pictures of difficult-to-treat wounds and upload them to an electronic healthcare record, thereby facilitating visual wound tracking and treatment evaluation. Photographic documentation can both enhance treatment and aid in defending against allegations of substandard wound care. Inconsistent or unsecured digital imaging techniques may result in resident privacy breaches and/or low-quality photographs that may potentially diminish credibility and inflate damage awards.
- **Communication and Collaboration:** Encourage open communication and collaboration among staff members, residents, and families to help ensure all aspects of care are addressed and expectations are managed. Document communication to and among healthcare providers, including consultations with wound care specialists or other specialists, which demonstrates that all members of the care team are informed and involved in the resident's care. Open and timely communication channels are essential for promptly identifying and addressing changes in a resident's condition. This includes promptly reporting concerns, updating care plans, and ensuring that all stakeholders are informed and involved in decision-making processes related to the resident's care. Communicate with providers and families when there is a change in condition. Discussions with residents or their legal representative(s) regarding the care plan, including risks and benefits of interventions, should also be documented to establish that the resident or family was aware of the injury and involved in treatment decisions.
- **Training and Education:** Provide staff with education and training on skin assessment/evaluation and pressure injury prevention, including the use of proper techniques for repositioning and skin care. Staff education and determination of competency should be documented using a formal competency tracking tool.
- **Tracking/Trending:** Pressure injury data should be analyzed, tracked, trended and monitored to determine the outcomes of interventions. Provide data to the quality assurance/performance improvement meetings for additional review and recommendations.

Spotlight on Pressure Injury Risk Management

For more risk control strategies related to pressure injuries, please access the CNA *CareFully Speaking*® publications entitled "Pressure Injuries: Sound Documentation is Key to Defensibility" and "Photographic Wound Documentation: Ten Guidelines to Help Minimize Digital Imaging Exposures."

Resident Abuse

For skilled nursing facilities, the average total incurred of resident abuse claims has increased by 45.7 percent since the 2021 dataset ($257,524 to $375,338), with the assisted living average total incurred increasing by 17.3 percent ($337,892 to $396,263), as shown in **Figure 13**.

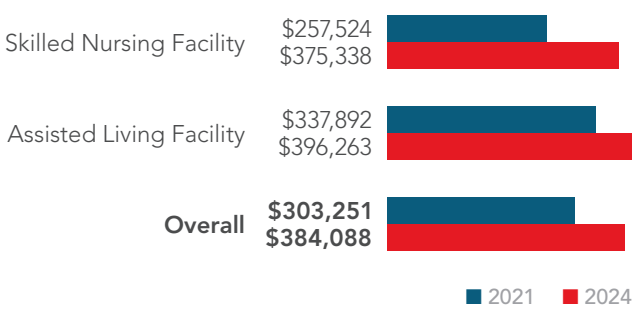
Resident abuse claims can result in significant financial loss and reputational harm. The following case scenario provides an example of an abuse incident that occurred in a memory care unit:

> *An aide reported a late-night fall by an 82-year-old female memory care facility resident with advanced dementia. The aide stated that the resident had tripped but was not injured. By the next morning, the staff observed that the resident was not acting like herself. They noted the incident report regarding the fall and, upon examining the resident, found that she grimaced with manipulation of her left leg. The family and physician were notified of the fall, and the resident was taken to the emergency department for treatment, where she was diagnosed with a hip fracture. The Director of Nursing initiated a review of the facility's video system which revealed that the aide had forcefully pushed the resident to the floor. The aide was immediately terminated, and the incident was reported to the state department of health and local law enforcement.*
>
> *The resident underwent surgery to repair the hip fracture. However, the resident's condition deteriorated post-surgery, and she expired less than two weeks later.*
>
> *In addition to criminal charges against the aide, the family initiated a suit against the facility that was settled for policy limits during mediation.*

This case highlights the vulnerability of residents to abuse, which increases with cognitive disabilities such as dementia. It is especially important for facilities caring for vulnerable populations to engage in proactive abuse prevention activities and establish reliable processes to support identification of abuse, investigation of abuse events, and reporting abuse to the appropriate authorities.

13 Average Total Incurred of Resident Abuse Claims by Bed Type

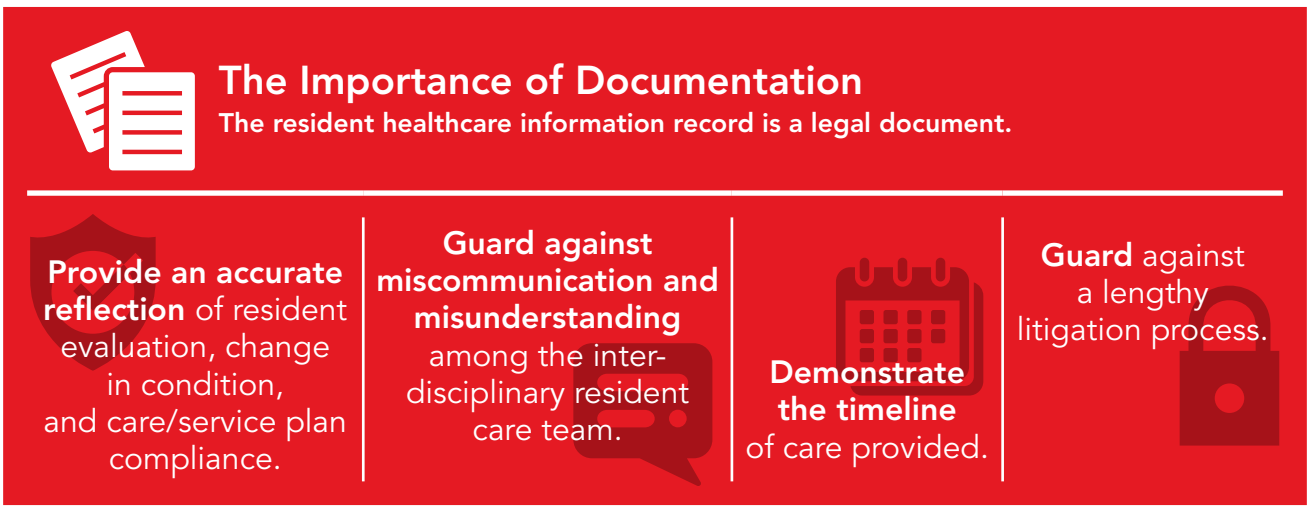
Closed Claims with Paid Indemnity of ≥ $10,000



The **average total incurred of resident abuse claims** in skilled nursing facilities **has increased by 45.7 percent** since the 2021 dataset ($257,524 to $375,338), with the **assisted living average total incurred increasing by 17.3 percent** ($337,892 to $396,263).

Resident Abuse Risk Management Recommendations

- **Comprehensive Resident Assessment/Evaluation:** Complete a comprehensive resident assessment/evaluation prior to admission to ensure resident behaviors can be managed by the facility staff. Documenting assessments/evaluations demonstrates a proactive approach to prevention and care.
- **Care/Service Plan Development and Implementation:** Develop and implement a care/service plan specific to the resident's behavior. This includes interventions such as identifying triggers that lead to behaviors, redirection, medication management, and activities.
- **Documentation:** Document the ongoing monitoring and evaluation of the resident's behavior, along with observations of family interactions and response to interventions. Changes in behaviors should be documented and reported to the provider and family, with adjustments made to the care/service plan.
- **Communication:** Encourage open communication and collaboration among staff members, residents and families to help ensure all aspects of care are addressed and expectations are managed. Document communication to and among healthcare providers, including observation of and changes in behaviors. Communicate with providers and families when there is a change in condition. Discussions with the resident or their legal representative regarding the care plan, including risks and benefits of interventions, should also be documented.
- **Comprehensive Staff Training and Education:** Provide thorough training on dementia care, including the symptoms and behaviors associated with the condition, effective communication techniques, and strategies for managing challenging behaviors without resorting to coercion or force. Offer specific training on recognizing and reporting signs of abuse, including physical, verbal, emotional, and financial abuse, as well as neglect. Incorporate training on ethical standards, empathy, and maintaining professional boundaries in caregiver-resident relationships.
- **Regular Supervision and Oversight:** Implement regular sessions where supervisors observe staff interactions with residents, provide feedback, and address any concerns or areas for improvement. Conduct unannounced spot checks to ensure compliance with policies and protocols related to resident care and safety. Foster an open-door policy where staff feel comfortable promptly reporting concerns or instances of abuse without fear of retaliation.



- **Strengthen Hiring Practices:** Screen potential employees rigorously, including background checks, reference checks, and evaluations of previous work experience in caregiver roles. Prioritize candidates who demonstrate empathy, patience, and a genuine commitment to the well-being of residents. Provide ongoing education and training opportunities to ensure staff remain current on best practices in dementia care and abuse prevention.
- **Promote a Culture of Respect and Dignity**: Establish and enforce a zero-tolerance policy for abuse of any kind within the facility. Encourage staff to treat residents with empathy, kindness, and dignity, fostering meaningful connections and relationships. Create opportunities for residents to provide feedback and participate in decision-making processes regarding their care, empowering them to advocate for themselves and voice any concerns that they may have.
- **Incident Reporting and Investigation:** Develop clear protocols for reporting suspected abuse, including procedures for documenting incidents, conducting investigations, and involving appropriate authorities when necessary. This includes notification of the resident's family and physician, notification of law enforcement (when indicated), reporting to state agencies as required and reporting to the insurance carrier in accordance with the terms and conditions of the policy. Ensure that all staff are aware of their responsibility to report any concerns or observed incidents of abuse, either involving other staff, residents or visitors, promptly and accurately. Establish mechanisms for supporting victims of abuse and witnesses of abuse through access to counseling services and critical incident stress debriefings.
- **Tracking/Trending:** Track, trend and analyze behavior data to determine patterns and the outcome of interventions. Include a review of data during quality assurance/performance improvement meetings.

Addressing an Allegation of Abuse

1 Ensure Safety
Move the resident away from the suspected abuser. Provide necessary medical care.

2 Report
Notify facility administration. Report to Adult Protective Services, law enforcement, insurance provider and any other regulatory agencies as required by your state.

3 Gather Information
Interview the resident, staff, and witnesses. Collect evidence and document findings.

4 Review and Take Action
Conduct an internal review and take disciplinary action as appropriate. Evaluate the need for policy changes to prevent recurrence.

5 Follow-up
Monitor resident's well-being. Ensure resident's family and physician are informed.

Spotlight on Resident Safety

For additional resources on resident safety, review the CNA *CareFully Speaking*® publications entitled "Memory Care: Creating Safer Settings for the Cognitively Impaired" and "Resident on Resident Sexual Abuse: Taking Aim at a Growing Risk."

Elopement

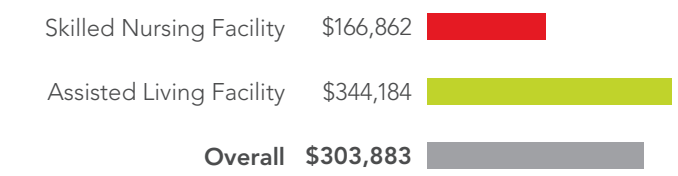
While elopement claims are limited in frequency, these claims continue to be a source of financial loss and reputational harm for aging services organizations, with an average total incurred of $303,883 in the 2024 dataset, as shown in **Figure 14**. Assisted living facilities may include memory care units where residents with exit-seeking behaviors reside, thereby increasing the risk for elopement. Memory care units may employ a variety of philosophies regarding the use of alarms as a restraint and may use other means to reduce the risk of elopement that are considered less restrictive, potentially resulting in a heightened exposure.

Elopements may involve allegations of improper resident monitoring, and they can also result in serious injuries such as death, fractures, and head injuries. As noted in **Figure 15**, 45.5 percent of elopements result in death, with an average total incurred of $417,141 (**Figure 16**). The following case scenario demonstrates the potential for tragic consequences following an elopement.

A 72-year-old female resident with a history of dementia, cognitive impairment and unwitnessed falls was found outside of the assisted living facility by a staff member exiting the building following her shift. The resident was found unresponsive and lying in a snowy embankment. It was unknown how long she had been lying there during a day of below-freezing temperatures. Investigation revealed that the facility door had been mistakenly left unlocked. The resident was taken to the local emergency department for treatment of hypothermia. She was hospitalized, but never regained full consciousness. She expired less than a week later. A regulatory investigation of the facility ensued, resulting in multiple citations, and a liability claim was subsequently filed. The case was settled for $525,000.

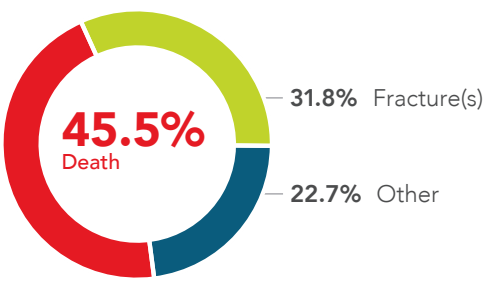
14 Average Total Incurred of Elopement Claims by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000



15 Distribution of Elopement Related Injuries

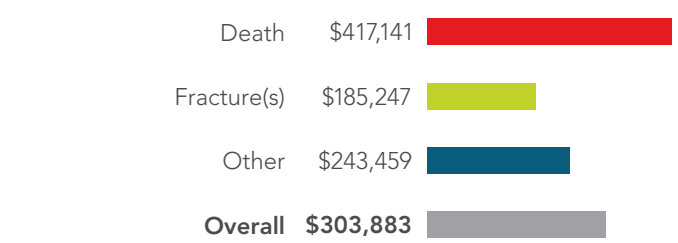
Closed Claims with Paid Indemnity of ≥ $10,000



While **elopement claims** are limited in frequency, these claims continue to be a **source of financial and reputational harm** for aging services organizations, with an **average total incurred of $303,883** in the 2024 dataset.

16 Average Total Incurred of Elopement Related Injuries

Closed Claims with Paid Indemnity of ≥ $10,000



The following case scenario includes many challenges that hampered the defensibility of the case. It also denotes the impact that negative media coverage can have on the outcome.

A 68-year-old male resident of the secured memory care unit of an assisted living facility was known to wander throughout the facility at night and would frequently sleep the majority of the day. He was observed early one morning sleeping on furniture in a common area of the facility. Staff encouraged him to go to the dining area for breakfast, but he declined and shuffled towards his room. There was no documentation of resident checks throughout the day. Later that night, a staff member conducting periodic rounds found the resident deceased on an outside patio after a day of sweltering heat. While the patio door was locked and only accessible via a key-coded exit door, the resident had previously been found in the area unsupervised. The prior incident had not been properly investigated. Questions were raised as to whether the resident had discovered the keypad code for the door and accessed the patio or if the door was malfunctioning. While residents with exit seeking behavior were encouraged to wear a device that would cause alerts if they tried to access external doors, the staff recalled that the resident's family had declined the pendant. There was no documentation in the healthcare information record indicating a discussion with family members about the safety benefit of the pendant or their declination. Due to these challenges, as well as extensive negative media coverage of the incident, the facility requested to settle the case before trial for $1,000,000.

Elopements may involve **allegations of improper resident monitoring**, and they can also result in **serious injuries** such as **death, fractures and head injuries**.

Resident Elopement Most Frequently Results from Failure to:

- **Assess/evaluate residents' risk of elopement upon admission, at least quarterly thereafter and following any change in condition.**
- **Maintain sufficient staff to monitor residents' whereabouts.**
- **Employ alarms or other devices to prevent elopement and/or wandering.**
- **Ensure that staff respond appropriately to alarms and missing resident situations.**

Spotlight on Resident Safety

For information on the impact of regular rounding on resident safety, access the AlertBulletin® "Hourly Resident Rounding: Key to Enhanced Safety and Satisfaction."

Elopement Risk Management Recommendations

- **Assessment/Evaluation:** Perform elopement assessments/evaluations upon admission, quarterly, with change in condition, and after an elopement. Review elopement risk in daily meetings, weekly at-risk meetings and include wandering/exit seeking trends in quality assurance/performance improvement meetings.
- **Care/Service Planning:** Document elopement risk in the care/service plan with resident-specific interventions. Document the resident's functional and cognitive level in the healthcare information record.
- **Documentation:** Observe and document the resident's wandering behavior and analyze observations to understand underlying causes and motivation. Document non-compliance with exit-seeking/elopement risk mitigation efforts. Update care/service plan to reflect non-compliance with exit-seeking/elopement risk mitigation interventions. Maintain and have readily available resident identification information. Conduct regularly scheduled, purposeful rounding to monitor resident whereabouts and needs, and maintain rounding records.
- **Monitoring Systems:** Ensure door locks, facility alarms, personal alarms, key codes/fobs, cameras, and other security equipment are in proper working order through ongoing inspections and testing protocols. Alarms should be evaluated regularly to confirm that they are audible. Document monitoring activities and maintain preventative maintenance records. Implement keypad integrity programs, which include changing codes periodically and when a breach occurs. Key fobs should not be distributed to unauthorized users such as family members. Review manufacturer instructions/specifications when developing device testing protocols. Consider using surveillance cameras as permitted by regulations and implement video retention procedures. Monitor weather conditions and activate appropriate restrictions and recovery actions when outside patios and courtyards are accessible to residents, visitors, and staff members. Engage law enforcement in missing resident protocols as soon as a resident is noted to be missing.
- **Communication:** Communicate with providers and families when there is an exit-seeking incident or change in condition. Monitor exit-seeking behaviors to identify triggers and communicate to the healthcare team. Create a work environment that initiates team huddles when a resident's clinical changes warrant further assessment and evaluation.
- **Root Cause Analysis:** Conduct a root cause analysis as an element of the elopement incident investigation, including identification of contributing factors. Document and monitor contributing factors and implementation of interventions to minimize the risk of reoccurrence. Trend near misses to identify other contributing factors and areas of exposure.
- **Training and Education:** Train staff, family members, and visitors on how to avoid resident "tailgating" activity. Train staff on response protocols and specified roles in searching for a missing resident upon hire and annually, with documentation maintained in personnel files. Formalize and train staff on a missing resident policy and procedure, in consultation with local authorities. Periodically conduct facility-wide elopement drills and analyze results. Address deficiencies with action plans.

Spotlight on Elopement

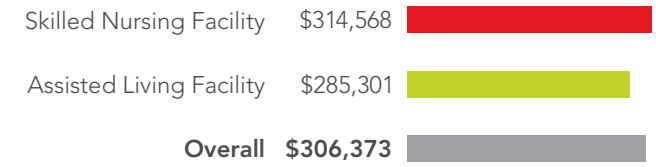
Additional resources on elopement may be found in the CNA *CareFully Speaking*® entitled "Wandering and Elopement: Assessing and Addressing the Risks."

Medication Errors

Medication errors present substantial risks and costs to the aging services industry. While the frequency of medication errors resulting in resident harm is relatively low, representing less than 2 percent of the total claims within the dataset as shown in **Figure 17**, these errors have the potential to cause significant injuries to residents, resulting in claims with high severity, with an average total incurred of $306,373 in the 2024 dataset.

17 Average Total Incurred of Claims with Medication Error by Bed Type

Closed Claims with Paid Indemnity of ≥ $10,000

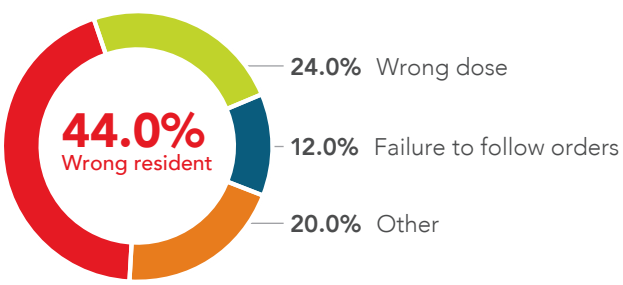


Medication errors that result in resident death or serious injury are considered "never events." Medication errors involving the wrong drug, wrong dose, wrong resident, wrong time, wrong rate, wrong route of administration or wrong preparation are categories where the implementation and practice of medication safety procedures and/or protocols may help prevent mistakes, resident injuries and potential claims from occurring. As seen in **Figure 18**, 44.0 percent of medication errors involve administration to the wrong resident. Wrong dose accounts for 24.0 percent of medication errors, with an average total incurred of $457,189 (**Figure 19**).

As the complexity of resident care in skilled nursing and assisted living settings increases, and the use of high-risk medications becomes more common, the potential for medication errors leading to devastating resident outcomes increases. **Figure 20** notes that 44.0 percent of medication errors involved opioids, with an average total incurred of $273,696 (**Figure 21**). Implementing robust medication management systems, enhancing staff training, and improving communication among healthcare providers can help reduce these errors and their associated impact. Furthermore, emphasizing resident safety and implementing a continuous quality improvement program are vital to reducing the risks associated with medication errors in these environments.

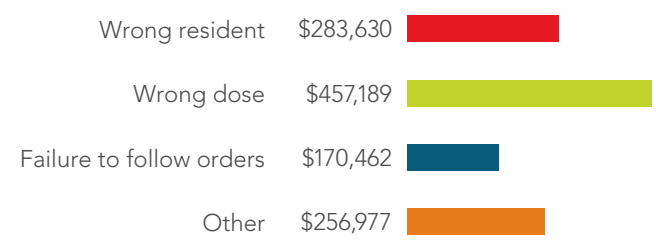
18 Distribution of Medication Errors

Closed Claims with Paid Indemnity of ≥ $10,000



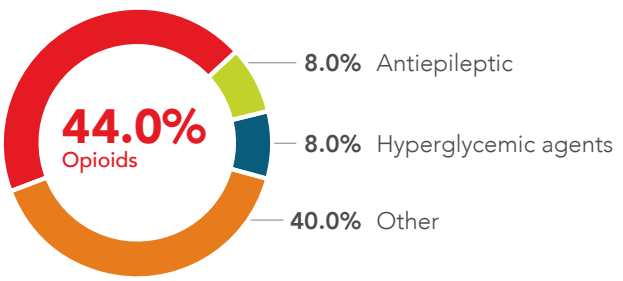
19 Average Total Incurred of Medication Errors

Closed Claims with Paid Indemnity of ≥ $10,000



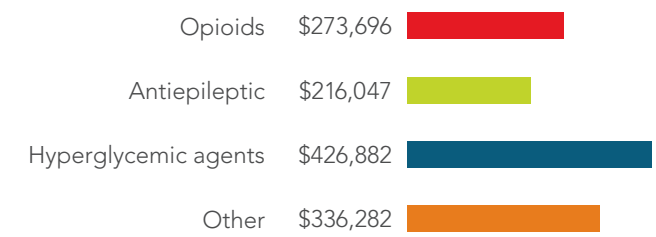
20 Distribution of Drugs Involved in Medication Errors

Closed Claims with Paid Indemnity of ≥ $10,000



21 Average Total Incurred of Drugs Involved in Medication Errors

Closed Claims with Paid Indemnity of ≥ $10,000



The following case scenarios provide examples of the impact that medication errors can have on aging services organizations:

A 78-year-old was admitted to a skilled nursing facility for rehabilitation following a hip fracture. She had a history of heart failure and coronary artery disease. Her medications included a diuretic and an antibiotic. During a busy morning shift, the resident's nurse mistakenly gave her medications intended for another resident. The medications included glipizide, clopidogrel, carvedilol, sertraline, gabapentin, levothyroxine, amitriptyline, duloxetine, allopurinol, and potassium supplements. After receiving the wrong medications, the claimant experienced severe abdominal pain, intense episodes of vomiting, hypoglycemia, and hypotension. Despite showing signs of distress, the nursing staff did not recognize the resident's deteriorating condition and did not initiate her transfer to the emergency department until more than 24 hours later. Upon arrival at the hospital, she was diagnosed with bradycardia and atrioventricular (AV) heart block, which progressed to multisystem organ failure. Her condition continued to deteriorate, and she passed away six days after the medication error. This case settled in mediation for $425,000.

A 74-year-old resident of a skilled nursing facility, with a history that included chronic renal insufficiency and congestive heart failure, was alert, oriented, and visiting with his wife when the nurse entered the room to administer morning medications. The nurse administered 45mg of extended-release morphine to the resident. This medication was not prescribed to him and was intended for his roommate.

The nurse responsible for the error promptly notified the physician of the mistake. Orders were given to closely monitor the claimant for any adverse effects of the morphine administration. Three hours after receiving the extended-release morphine, the resident began to experience a sudden change in consciousness and skin color. The nurse noticed he was making a gurgling noise and exhibiting signs of respiratory distress, indicating potential opioid toxicity.

The nurse administered a dose of Narcan (naloxone), a medication used to counteract the effects of opioids. Unfortunately, the resident did not show any obvious response to the drug. Recognizing the severity of the situation, the nurse called 911 for assistance. The claimant was emergently transported to the nearest hospital emergency department for further evaluation and treatment.

In the emergency department, his condition continued to deteriorate. He progressed into respiratory failure, metabolic acidosis, and multiorgan failure despite aggressive medical interventions. He passed away shortly after arriving at the ED. His cause of death was determined to be respiratory failure related to morphine administration. This case settled in mediation, with a total incurred of more than $500,000.

While the frequency of **medication errors** resulting in resident harm is relatively low, these errors have the **potential to cause significant injuries to residents** resulting in claims with high severity, with an **average total incurred of $306,373** in the 2024 dataset.

Medication Administration Risk Management Recommendations

Safe medication administration in healthcare depends upon reliable processes that decrease variability and the likelihood of errors. Robust systems and protocols ensure that medications are prescribed, dispensed, and administered correctly, reducing the risk of harm to residents. By standardizing procedures and promoting a culture of safety, aging services facilities can enhance resident outcomes and minimize the occurrence of medication errors. The following recommendations focus on the medication administration processes:

- **Resident Identification and Dose Verification:** Use at least two resident identifiers (e.g., name and date of birth, photo) before administering medications. Implement a double verification process for high-risk medications to confirm accurate dosing. Implement barcode scanning systems for medication administration to ensure the right medication is given, at the right dose, to the right resident.
- **Medication Reconciliation:** Conduct thorough medication reconciliation upon admission, transfer, and discharge of residents. Regularly review and update residents' medication lists to prevent errors related to outdated information.
- **Staff Training and Education:** Provide comprehensive training to staff members involved in medication administration on the proper procedures and the importance of double-checking. Offer ongoing education and regular competency assessments to reinforce safe medication practices.
- **Standardized Procedures:** Develop standardized procedures for medication administration, including double-checking protocols for high-risk medications, especially for residents with similar names. Ensure that procedures are consistently followed and regularly reviewed for effectiveness.
- **Communication:** Encourage open communication among staff members regarding medication orders, changes, and concerns. Use standardized communication tools (e.g., SBAR – **S**ituation, **B**ackground, **A**ssessment, **R**ecommendation) to convey critical information about medication administration.
- **Technology Utilization**: Implement electron ic health records (EHRs) with built-in medication alerts and reminders. Use electronic medication administration records (eMARs) to document medication administration to reduce the risk of errors.
- **Environmental Factors:** Minimize distractions and interruptions during medication administration by creating a quiet and focused environment. Ensure that medication storage areas are organized and clearly labeled to prevent mix-ups.
- **Quality Improvement Initiatives:** Conduct regular audits and reviews of medication administration processes to identify areas for improvement. Establish a system for monitoring medication administration practices and providing feedback to staff. Encourage reporting and analysis of medication errors and near misses to identify root causes and implement corrective actions.
- **Collaboration with Pharmacy Services:** Engage pharmacy services in medication management, including medication reconciliation, review of orders, and monitoring for drug interactions. Seek pharmacist input for high-risk medications or complex medication regimens.
- **Incident Reporting:** Ensure that all medication errors and near misses are captured through the incident reporting process. Encourage a culture of safety that empowers staff to report errors and near misses without fear of retribution.

High-Risk Medications and Rescue Protocols

Rescue protocols for high-risk medications such as opioids offer a range of important benefits to aging services organizations. One of the primary advantages is the assurance of rapid response in situations involving overdose or adverse reactions. Aging services organizations should identify high-risk medications given to residents and establish standard protocols to quickly detect and address overdoses or adverse reactions. By providing a structured framework for immediate intervention, these protocols can significantly enhance resident outcomes and save lives.

Rescue protocols improve communication among aging services team members. During emergencies, clear and effective communication is essential for coordinating response efforts. Protocols ensure that everyone involved is informed and knows their role, reducing the risk of confusion or miscommunication.

The following describes vital elements of a rescue protocol for an opioid overdose. It is important to note that this is a general example, and specific rescue protocols may vary based on organizational policies and available resources.

Rescue Protocol – Opioid Use

1. **Recognition of Opioid Overdose:** Aging services providers should be trained to recognize the signs and symptoms of opioid overdose, such as respiratory depression, altered mental status, and pinpoint pupils. If opioid overdose is suspected, staff should call 911 for emergency assistance.
2. **Initial Assessment:** Upon suspecting opioid overdose, the aging services provider should assess the resident's vital signs, level of consciousness, and respiratory status.
3. **Administration of Naloxone:** If opioid overdose is suspected, and the resident is unresponsive or has inadequate breathing, naloxone should be administered immediately. The dose and route of administration depend upon the specific naloxone formulation available (e.g., intranasal, intramuscular, intravenous).
4. **Monitoring and Supportive Care:** After administering naloxone, the resident should be closely monitored for signs of improvement or relapse. Supportive care, including airway management and oxygen therapy, should be provided as needed.
5. **Reassessment and Repeat Dosing:** If the resident does not respond to the initial dose of naloxone, additional doses may be administered at intervals based upon the specific naloxone formulation and the resident's response. Due to the prolonged effects of extended-release opioids, multiple doses may be necessary.
6. **Referral for Further Care:** The resident should be referred to a higher level of care for further evaluation and treatment of opioid overdose.
7. **Documentation:** An objective, detailed record of the opioid overdose event, including the administration of naloxone and the resident's response, should be documented in the resident's healthcare information record.

Aging services organizations should **identify high-risk medications** given to residents and **establish standard protocols** to quickly detect and address **overdoses or adverse reactions**.

Disclosure of an Adverse Event

Disclosure of an adverse event is a practice that can reduce the likelihood of litigation. When disclosing an adverse event to a resident and/or the resident's family, the situation should be approached with empathy, transparency, and sensitivity. Administrators and clinical leaders should receive training regarding the proper disclosure of adverse events. Some recommendations for effectively communicating such sensitive information includes the following:

1. **Prepare in Advance:** Gather all relevant information about the adverse event before initiating the conversation, including details of what occurred, the actions taken by the facility, and any steps being taken to address the situation. Anticipate potential questions or concerns the family may have and prepare appropriate responses.
2. **Choose the Right Setting:** Select a private and comfortable environment for the discussion, ensuring that both parties can speak openly without distractions or interruptions. Consider inviting a neutral third party, such as a social worker or counselor, to provide support and facilitate the conversation if necessary.
3. **Be Honest and Transparent:** Begin the conversation by acknowledging the seriousness of the situation and expressing genuine concern for the resident's well-being and the family's concerns. Provide a clear and factual account of the adverse event, including when it occurred, who was involved, and the impact it had on the resident. Avoid downplaying or minimizing the severity of the incident, as this can erode trust and credibility.
4. **Listen Actively:** Allow family members ample opportunity to express their thoughts, feelings, and questions regarding the adverse event. Practice active listening, demonstrating empathy and understanding, and validating their emotions and concerns. Encourage open communication and reassure the family that their perspectives are valued and taken seriously.
5. **Offer Support and Assistance:** Assure the family that the resident's safety and well-being are the facility's top priorities, and outline the steps being taken to address the situation and prevent future occurrences. Provide ongoing updates and communication as the situation progresses, maintaining transparency and accountability throughout the resolution process.

Responding to Adverse Events

Adverse events should be reported to a clinical supervisor or risk manager per policy requirements, and an incident report should be completed promptly. Adverse events include incidents involving one or more of the following:

- ☐ A resident is harmed or sustains an injury.
- ☐ An outcome has potential clinical significance.
- ☐ An outcome differs from anticipated results.
- ☐ An unexpected safety crisis.

For more information on resident safety and responding to adverse events, we recommend consulting the following resources:

- CMS Adverse Events in Nursing Homes
- AHRQ: TeamSTEPPS® Training
- Institute for Safe Medication Practices (ISMP)
- Institute for Healthcare Improvement (IHI)
- National Quality Forum (NQF)

Closing Comments

The CNA *Aging Services Professional Liability Claim Report: 12th Edition* provides insight into risk exposures that have continued to drive losses in aging services organizations, along with additional exposures that create new challenges for risk mitigation.

This report provides case scenarios and risk recommendations to assist with developing and implementing risk mitigation strategies for industry loss drivers. We hope that the information provided in this report will help organizations to identify areas of potential risk exposure and implement proactive mitigation measures. Aging services organizations should continue to evaluate and update their risk management processes, while implementing best practices to mitigate risk. Actions to consider and adapt to the individual aging services environment may include the following, amongst others:

- Establish comprehensive orientation and training programs for employed and contracted staff to minimize potential gaps in training that could lead to resident injury and potential litigation.
- Emphasize the importance of clinical documentation skills and proper use of electronic healthcare information records to maintain quality and continuity of care, receive reimbursement, and defend claims.
- Standardize processes to reduce variations in services and prevent errors that may harm residents.
- Explore innovative care delivery models to ensure delivery of safe, consistent, and effective care. Innovative technologies can provide tools that can help reduce errors and harm in the aging services industry.
- Initiate honest and open dialogue about unanticipated healthcare outcomes with residents, their families and staff members in an effort to promote trust, transparency, and continuous improvement in healthcare delivery.
- Develop standardized response protocols for high risk – low volume situations that promote evidence-based practices, improved resident outcomes, and increased resident safety.

While new organizational challenges and risk exposures are emerging, there are loss drivers that will persistently produce claims, as illustrated in this *Aging Services Professional Liability Claim Report: 12th Edition*. An enterprise risk management program represents the best line of defense against the inflationary effects associated with these exposures. Leaders must reduce exposures in high and frequent risk areas by promoting a culture of safety, evaluating exposures on an ongoing basis, reporting and analyzing all incidents and near misses, and implementing and adjusting action plans. Resilient organizations demonstrate the foresight to anticipate, the initiative to prepare for, and the agility to respond effectively to unexpected challenges and disruptions that can result in resident safety exposures and claims.

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