

Mitigating Risk in Fall Management: Achieving Excellence Through Patient Safety



Kathleen Martin, RN, MSN, MPA, LNHA, CPHQ, WCC

KMartinConsulting



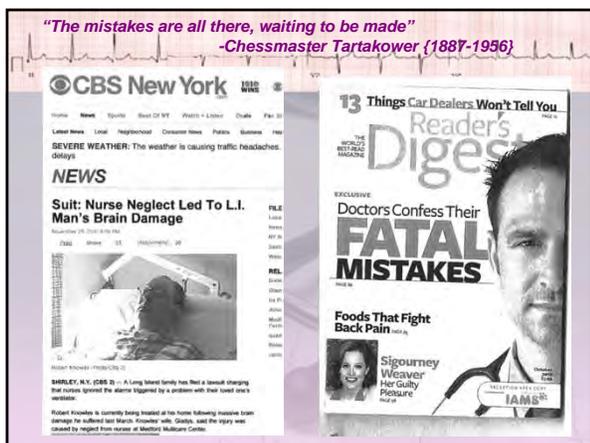


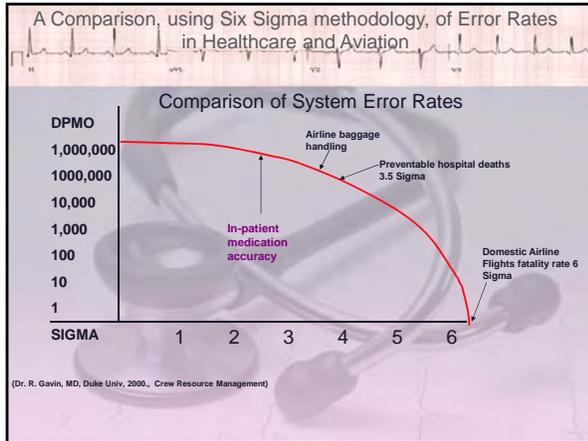
Program Goals

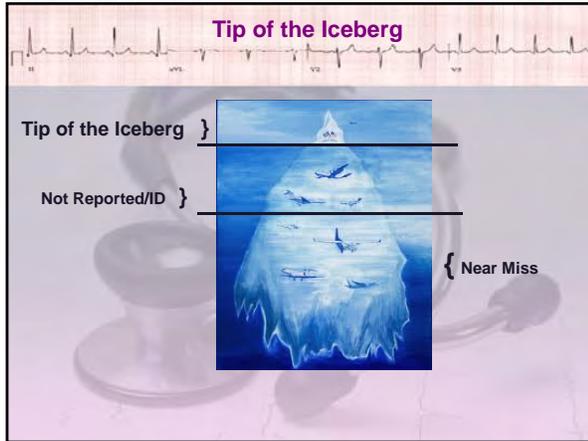
- Relate regulatory and legal standards of care to fall management in healthcare facilities.
- Discuss impact of media related to errors/mistakes in facilities.
- Discuss patient safety, medical Mistakes, Error management in general.
- Relate how good risk management practices can prevent suits as well as regulatory problems proactively, with specific strategy using CRM (Crew Resource Management).
- Using your data on falls effectively.
- How to improve documentation to avoid litigation and regulatory deficiencies.
- Discuss how surveyors may avoid helping attorneys! An unsolvable problem.
- How to assemble solid investigations that are bullet proof.
- Discuss specific legal/regulatory cases on falls, which demonstrates how easy fixes could have avoided such issues.











"I hate the goddamn system, but until someone comes along with some changes that make sense, I'll stick with it."
 -Clint Eastwood as "Dirty Harry" in Magnum Force, 1973

Research shows that the majority of errors, mistakes, near-misses are due to Systems Problems.

A patient fall is considered an error.

MAJOR SOURCES OF HUMAN ERROR

Errors of substitution: turning on hot water instead of cold in a shower.

Errors of selection: selecting CO2 instead of O2.

Errors of reading: a nurse may read 1.0 mg as 10 mg.

Errors of irritation: a caregiver may perform a task wrong when irritated with too many alarms and interruptions.

Errors of Alertness: the dangers of Physician residents working on multiple shifts; or nurses.

Errors of interchangeability: connecting an O2 tubing to NO2 source in anesthesia equipment, because the fittings of both are the same.

Errors of lack of understanding: an improperly trained staff is likely to make mistakes during emergencies.

Errors of sequencing: a med tech may not perform the work in a given sequence of a checklist and overlook an activity.

Errors of overconfidence: can occur when a physician sees familiar symptom and makes a quick dx.

Errors of reversal: a caregiver may increase the heart rate instead of decreasing it, not being aware of whether to turn the control clockwise or anti-clockwise.

Errors of unintentional activation: a care giver may inadvertently flip a life support switch to OFF instead of ON.

Errors of mental overload: a pharmacy tech prepared a chemo soln with 20% Nacl concentration instead of .9% resulting in a fatality. Investig revealed that she was distracted while working on her wedding plans. Her supervisor had to serve 6 mos of jail time. He overlooked her work because his own workload had increased due to computer sx being down.

Errors of causal behavior: sometimes a caregiver may not take a task seriously. A surgeon may not go through a scrub process when touched by another person.

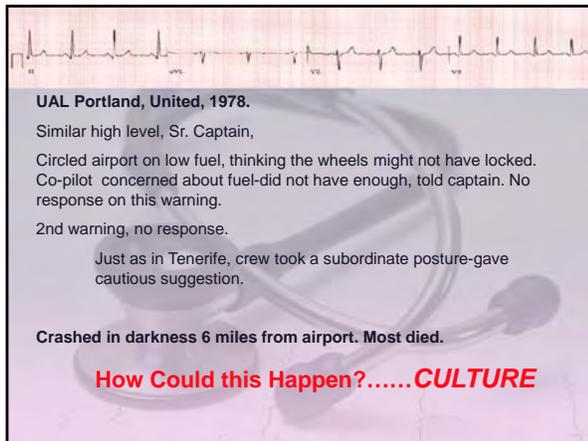
Error Management

Tragedy Prompted Development of Crew Resource Management

Concept being adopted by Healthcare now from the airline industry as a result of human error in crashes, and NASA.

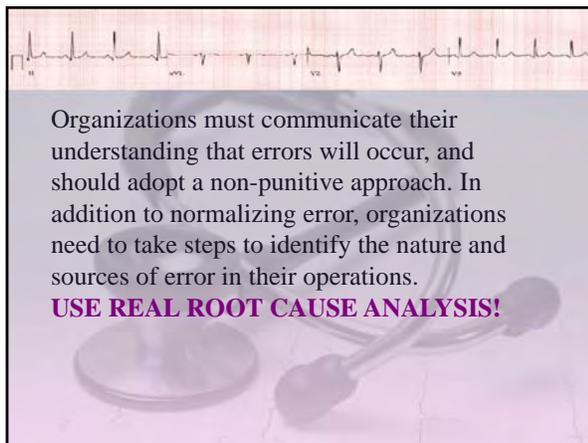
Tenerife, KLM, 1977.-captain=chief instructor pilot, 11k flight hrs, Sr. captain

- fatigue, impatience
- language
- heirarchy, crew won't question authority
- lax procedures

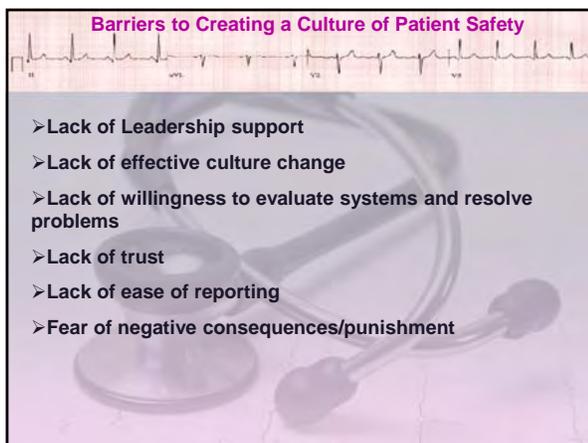


UAL Portland, United, 1978.
Similar high level, Sr. Captain,
Circled airport on low fuel, thinking the wheels might not have locked.
Co-pilot concerned about fuel-did not have enough, told captain. No response on this warning.
2nd warning, no response.
Just as in Tenerife, crew took a subordinate posture-gave cautious suggestion.

Crashed in darkness 6 miles from airport. Most died.
How Could this Happen?.....CULTURE



Organizations must communicate their understanding that errors will occur, and should adopt a non-punitive approach. In addition to normalizing error, organizations need to take steps to identify the nature and sources of error in their operations.
USE REAL ROOT CAUSE ANALYSIS!



Barriers to Creating a Culture of Patient Safety

- Lack of Leadership support
- Lack of effective culture change
- Lack of willingness to evaluate systems and resolve problems
- Lack of trust
- Lack of ease of reporting
- Fear of negative consequences/punishment

PUNITIVE Approach

Historically, punishment has been used to achieve perfection in medicine.

In the words of **Dr. Phil**:
"How has that been working for ya?"



DISCIPLINARY ACTION

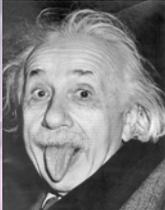
Questions to ask:

- Will disciplinary action serve to prevent future accidents?
- Did the individual intentionally violate safe practices, policies, and standards?
- Did a caregiver commit a deliberate reckless act?
- Is there a pattern of behavior?

The Non-Punitive Culture of Patient Safety

Albert Einstein: "The type of thinking that got us into this problems is not the type of thinking that will get us out."

"The definition of insanity is doing the same thing over and over again, and expecting different results."



How Do We Investigate Patient Incidents & Close Calls?

A Root Cause Analysis (RCA) team is initiated to determine:

- What happened?
- Why?
- How to prevent it from happening in the future?

An RCA is a process designed to examine the systems vulnerabilities to prevent adverse events:

- non-punitive
- multidisciplinary team approach
- process for identifying basic or contributing causes
- process for identifying what we can do to prevent recurrence

RCA Process

A process to identify the basic or contributing causal factors that underlie variations in performance associated with adverse events.

A tool for identifying prevention strategies.

Culture of Safety RCA Process: Emphasis on improving and redesigning systems and processes; Not on individual performance

1. Facts of Event
2. Causality Statements
3. Action Plan
4. Monitoring

RCA Goals

- Identify **WHAT** happened
- Identify **WHY** it happened***
- Identify **HOW** to prevent recurrence

Never Events Account for One in Six Claims

▼ Four hospital-acquired conditions comprise 12.2 percent of total medical professional liability costs:

- ▼ Hospital-acquired infections
- ▼ **Hospital-acquired injuries**
- ▼ Objects left in surgery
- ▼ Pressure ulcers

Night-time Acrobatics!!!

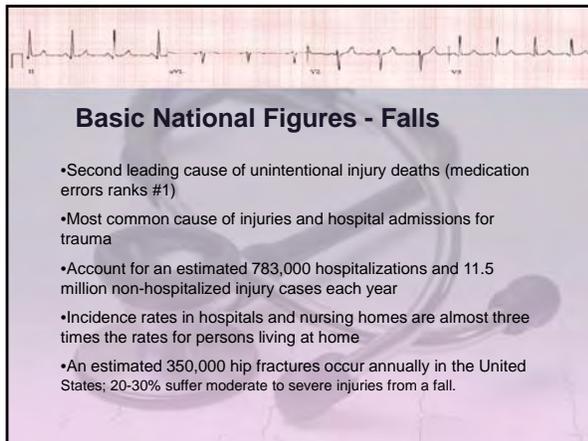


Reduce Risk of Harm From Falls

**Hospital falls have a 30% risk of physical injury
At risk populations: 1-4 and 85+ age groups
Increase of injury-related deaths in the elderly*

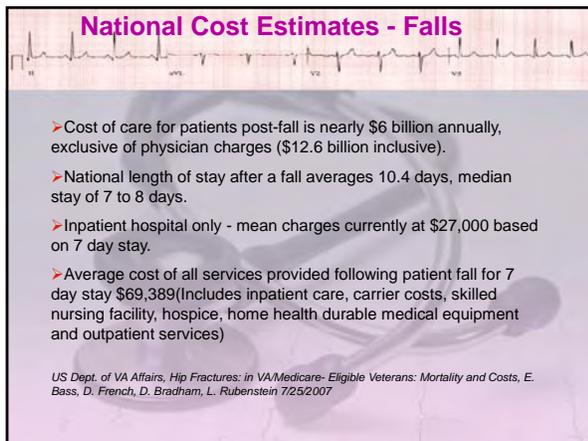


- Assess Fall Risk using Morse Scale (or other)
- on admission, each reassessment, and after a fall
- Use a Falling Leaf to indicate a patient is a high risk
- Implement fall prevention devices, alarms and equipment
- Correct spills or wet surfaces
- Dispose of trash appropriately
- Remove or report any trip hazards and environmental hazards immediately
- Examine for injury before moving the patient after a fall
- Notify the provider
- Complete Fall Review Note in CPRS & notify next of kin
- Implement additional fall precautions as indicated
- Complete a Post Fall Note within 24 hours after the fall



Basic National Figures - Falls

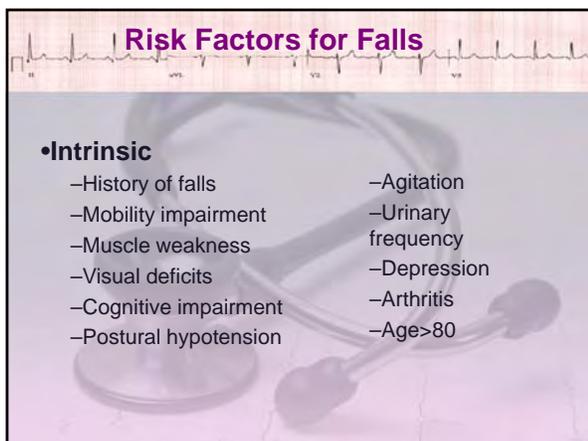
- Second leading cause of unintentional injury deaths (medication errors ranks #1)
- Most common cause of injuries and hospital admissions for trauma
- Account for an estimated 783,000 hospitalizations and 11.5 million non-hospitalized injury cases each year
- Incidence rates in hospitals and nursing homes are almost three times the rates for persons living at home
- An estimated 350,000 hip fractures occur annually in the United States; 20-30% suffer moderate to severe injuries from a fall.



National Cost Estimates - Falls

- Cost of care for patients post-fall is nearly \$6 billion annually, exclusive of physician charges (\$12.6 billion inclusive).
- National length of stay after a fall averages 10.4 days, median stay of 7 to 8 days.
- Inpatient hospital only - mean charges currently at \$27,000 based on 7 day stay.
- Average cost of all services provided following patient fall for 7 day stay \$69,389 (includes inpatient care, carrier costs, skilled nursing facility, hospice, home health durable medical equipment and outpatient services)

US Dept. of VA Affairs, Hip Fractures: In VA/Medicare- Eligible Veterans: Mortality and Costs, E. Bass, D. French, D. Bradham, L. Rubenstein 7/25/2007



Risk Factors for Falls

- Intrinsic**
 - History of falls
 - Mobility impairment
 - Muscle weakness
 - Visual deficits
 - Cognitive impairment
 - Postural hypotension
 - Agitation
 - Urinary frequency
 - Depression
 - Arthritis
 - Age>80

Risk Factors for Falls (cont.)

- Extrinsic/Environmental**
 - Medications; interactions/timing
 - Poor lighting/environmental issues
 - Loose carpets
 - Stimulating environments
 - entire area of patient's bed
 - positioning of equipment: call bell, table, commode, etc...

Strategies for Fall Prevention

<ul style="list-style-type: none"> •Multifactorial interventions <ul style="list-style-type: none"> -Education of staff -Review and modification of medications -Exercise and balance training; Rehab therapy intervention -Modification of environmental hazards -Team approach 	<ul style="list-style-type: none"> •Specific interventions <ul style="list-style-type: none"> -Bed alarms -Moving patient to room near RN station -Sitter for agitated patient -Placing patient's mattress on the floor -Family involvement
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Data...Data....Data.....DO YOU USE IT?

To "fix"/address the problem, must use data to compare pre and post intervention outcomes:

Is there a trend? What is the trend?

Were the interventions positive?

Or did we miss a trend?

Words of Encouragement....



"I am not remotely interested in just being good."

"Gentlemen, we are going to relentlessly chase perfection, knowing full well we will not catch it, because nothing is perfect. But we are going to relentlessly chase it, because in the process we will catch excellence."

Vince Lombardi, head coach Green Bay Packers, 1959 – 1967



More on Patient Safety-Analysis of an Error....

Crew Resource Management...in short

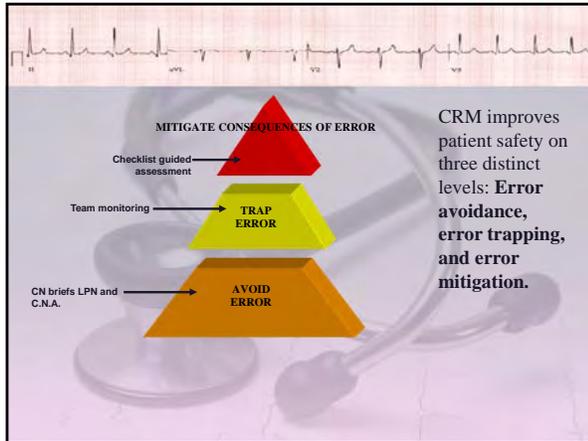
Underlying CRM is the premise that human error is inevitable as well as a valuable source of information. The goal is to prevent work overload situations that compromise situational awareness that can lead to errors.

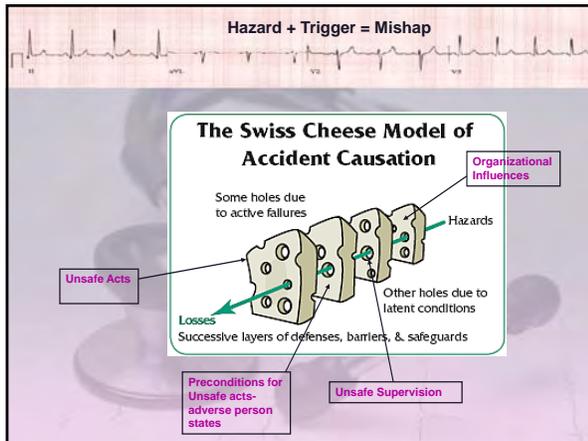
There are three lines of defense with error countermeasures.

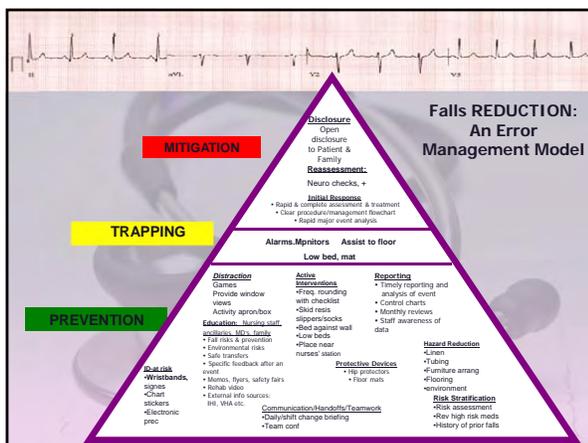
First there is **avoidance** of error.

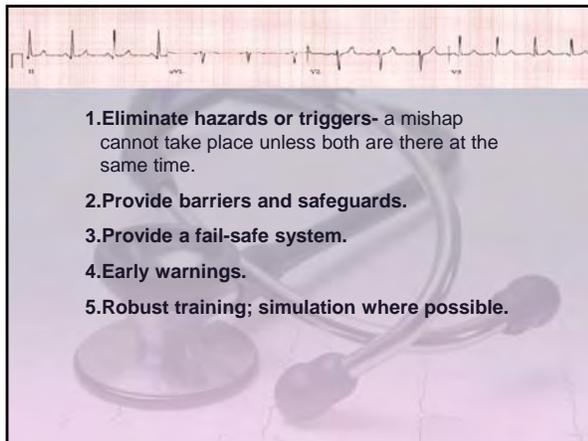
The second is **trapping** incipient errors before they are committed.

Lastly is **mitigating the consequences** of those errors which are not trapped.









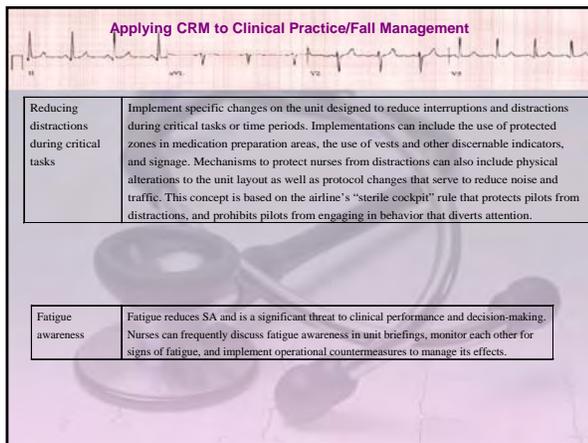
1. Eliminate hazards or triggers- a mishap cannot take place unless both are there at the same time.

2. Provide barriers and safeguards.

3. Provide a fail-safe system.

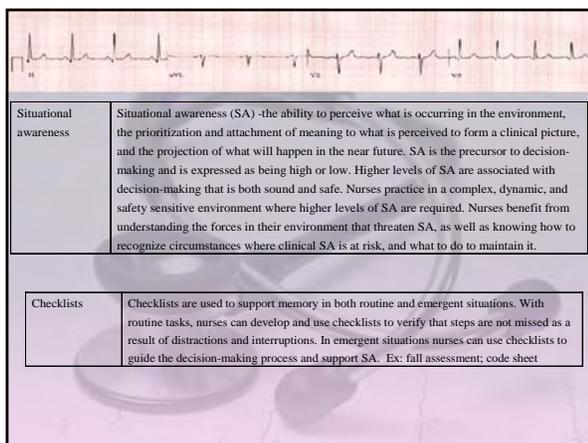
4. Early warnings.

5. Robust training; simulation where possible.

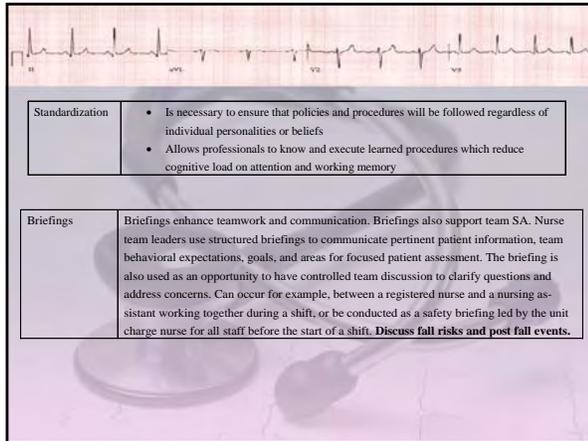


Applying CRM to Clinical Practice/Fall Management

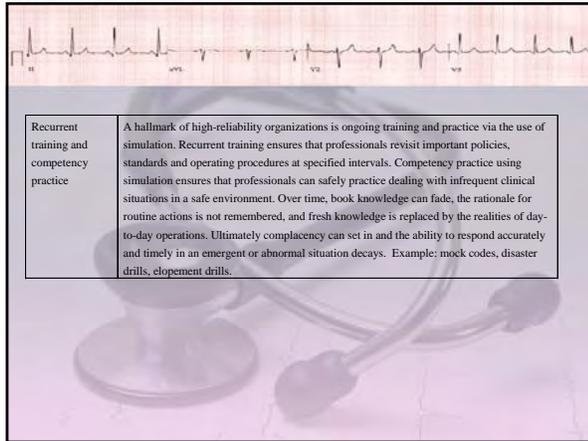
Reducing distractions during critical tasks	Implement specific changes on the unit designed to reduce interruptions and distractions during critical tasks or time periods. Implementations can include the use of protected zones in medication preparation areas, the use of vests and other discernable indicators, and signage. Mechanisms to protect nurses from distractions can also include physical alterations to the unit layout as well as protocol changes that serve to reduce noise and traffic. This concept is based on the airline's "sterile cockpit" rule that protects pilots from distractions, and prohibits pilots from engaging in behavior that diverts attention.
Fatigue awareness	Fatigue reduces SA and is a significant threat to clinical performance and decision-making. Nurses can frequently discuss fatigue awareness in unit briefings, monitor each other for signs of fatigue, and implement operational countermeasures to manage its effects.



Situational awareness	Situational awareness (SA) -the ability to perceive what is occurring in the environment, the prioritization and attachment of meaning to what is perceived to form a clinical picture, and the projection of what will happen in the near future. SA is the precursor to decision-making and is expressed as being high or low. Higher levels of SA are associated with decision-making that is both sound and safe. Nurses practice in a complex, dynamic, and safety sensitive environment where higher levels of SA are required. Nurses benefit from understanding the forces in their environment that threaten SA, as well as knowing how to recognize circumstances where clinical SA is at risk, and what to do to maintain it.
Checklists	Checklists are used to support memory in both routine and emergent situations. With routine tasks, nurses can develop and use checklists to verify that steps are not missed as a result of distractions and interruptions. In emergent situations nurses can use checklists to guide the decision-making process and support SA. Ex: fall assessment; code sheet



Standardization	<ul style="list-style-type: none"> • Is necessary to ensure that policies and procedures will be followed regardless of individual personalities or beliefs • Allows professionals to know and execute learned procedures which reduce cognitive load on attention and working memory
Briefings	<p>Briefings enhance teamwork and communication. Briefings also support team SA. Nurse team leaders use structured briefings to communicate pertinent patient information, team behavioral expectations, goals, and areas for focused patient assessment. The briefing is also used as an opportunity to have controlled team discussion to clarify questions and address concerns. Can occur for example, between a registered nurse and a nursing assistant working together during a shift, or be conducted as a safety briefing led by the unit charge nurse for all staff before the start of a shift. Discuss fall risks and post fall events.</p>



Recurrent training and competency practice	<p>A hallmark of high-reliability organizations is ongoing training and practice via the use of simulation. Recurrent training ensures that professionals revisit important policies, standards and operating procedures at specified intervals. Competency practice using simulation ensures that professionals can safely practice dealing with infrequent clinical situations in a safe environment. Over time, book knowledge can fade, the rationale for routine actions is not remembered, and fresh knowledge is replaced by the realities of day-to-day operations. Ultimately competency can set in and the ability to respond accurately and timely in an emergent or abnormal situation decays. Example: mock codes, disaster drills, elopement drills.</p>
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Nursing Home Abuse Must Be Stopped!

CHECK YOUR LOVED ONES CAREFULLY!

IT CAN TAKE LESS THAN 2 WEEKS FOR LIFE-THREATENING INJURIES TO OCCUR

THEY MAY SUFFER FROM:

- BED SORES
- BRUISES
- CUTS AND WELTS
- MALNUTRITION
- DEHYDRATION
- INFECTION

OR THE EFFECTS OF IMPROPER MEDICATION.

BY LAW, NEW JERSEY & NEW YORK NURSING HOMES MUST PUT PATIENT HEALTH & SAFETY AHEAD OF PROFITS

Hariton & D'Angelo

LONG ISLAND: 800 Veterans Memorial Highway, Suite 210, Hauppauge, NY 11788

NEW JERSEY: One Gateway, Suite 2600, Newark, NJ 07102

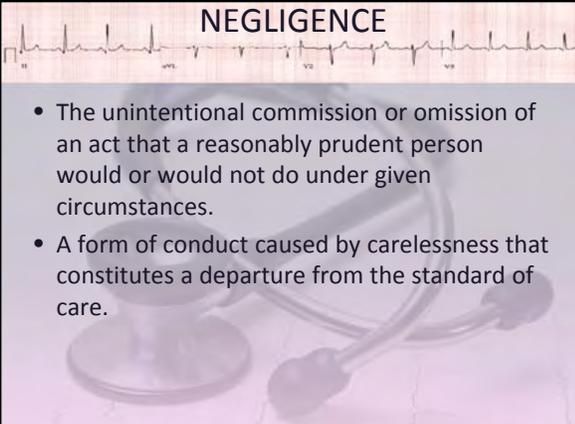
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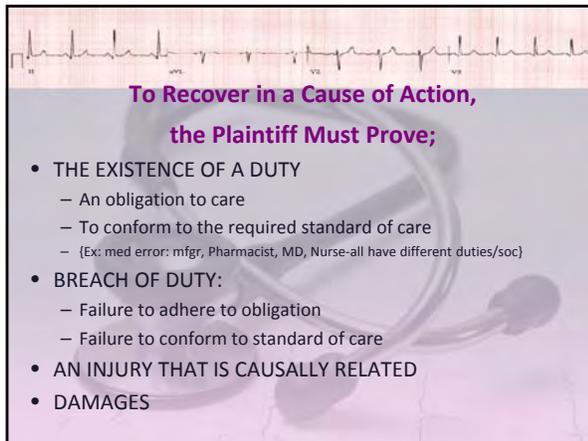
Torts

- A tort is a civil wrong...
- Committed against person/property...
- For which a court provides a remedy....
- In the form of damages
- Negligence is a form of a tort
- Intentional torts: Battery, defamation, false imprisonment, disclosure of confidential information, ...



NEGLIGENCE

- The unintentional commission or omission of an act that a reasonably prudent person would or would not do under given circumstances.
- A form of conduct caused by carelessness that constitutes a departure from the standard of care.



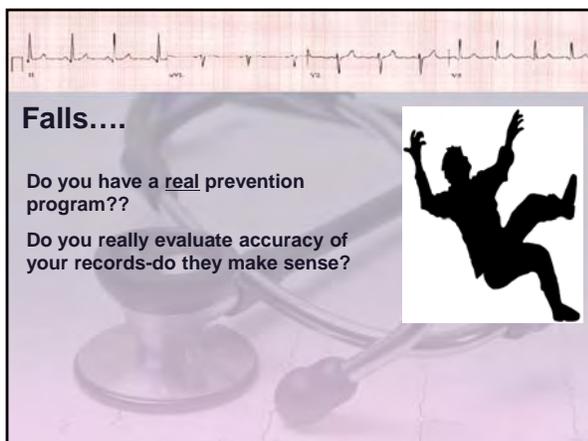
**To Recover in a Cause of Action,
the Plaintiff Must Prove;**

- THE EXISTENCE OF A DUTY
 - An obligation to care
 - To conform to the required standard of care
 - {Ex: med error: mfrgr, Pharmacist, MD, Nurse-all have different duties/soc}
- BREACH OF DUTY:
 - Failure to adhere to obligation
 - Failure to conform to standard of care
- AN INJURY THAT IS CAUSALLY RELATED
- DAMAGES



**The most problematic area for
all health care areas:**

- Safety issues:
 - Side Rail entrapment issues
 - Restraints
- Pt. falls:
 - SR left down on those deemed necessary
 - Medicated pts. Left unattended
 - Wheelchairs left unsecured, unlocked
 - Restraint use
 - Lack of regular rounding
 - Medication interactions, SE, etc...
 - Environmental



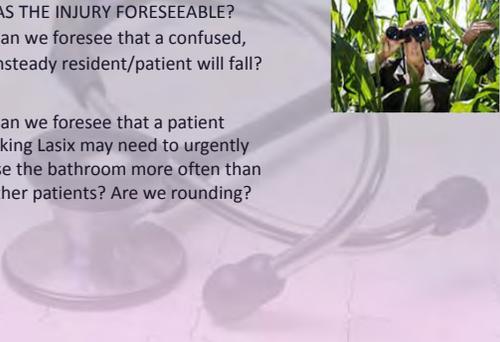
Falls....

Do you have a real prevention program??

Do you really evaluate accuracy of your records-do they make sense?

FORESEEABILITY

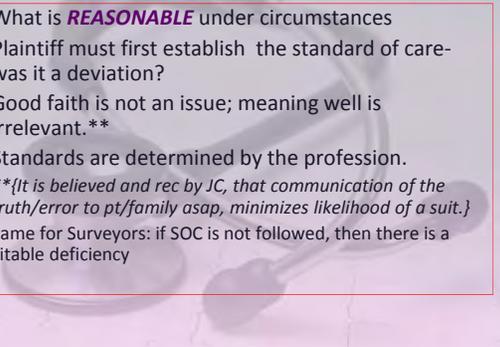
- WAS THE INJURY FORESEEABLE?
 - Can we foresee that a confused, unsteady resident/patient will fall?
 - Can we foresee that a patient taking Lasix may need to urgently use the bathroom more often than other patients? Are we rounding?

STANDARD OF CARE

*Usually your own policy

- What is **REASONABLE** under circumstances
- Plaintiff must first establish the standard of care- was it a deviation?
- Good faith is not an issue; meaning well is irrelevant. **
- Standards are determined by the profession.
- **{It is believed and rec by JC, that communication of the truth/error to pt/family asap, minimizes likelihood of a suit.}
- Same for Surveyors: if SOC is not followed, then there is a citable deficiency





Risk Management Issue:

If I get sued, {or if regulatory investigation} how will documentation help/hurt me?

"Half the game is 90 percent mental."

-Yogi Berra




Help....then hurt me.....

- You will know exactly what you did and when you did it.
- Lack of memory replaced by good charting.
- Thorough, legible notes look more professional
- If you fail to prepare the documentation you are liable,
- You will have difficulty remembering what, when, why you did it.
- Can appear unprofessional
- Poor recollection will appear defensive.

Charting Strategies:

- Write in ink and make the record "copyable"
- Line through empty spaces
- Addendums if it says "addendum"
- Date and pt name on each pg.
- Complete signature
- Document chronologically
- No entries in advance
- Correct spelling and grammar
- Write legibly-65% of text is illegible
- Use only approved abbreviations
- Know how to correct entries per policy-see "Correction of Medical Record Policy"
- Use FOCUS CHARTING techniques: Data, Action Response

*A word on
E-Mail!!!
Meta data*

Ask the following {RCA/Post Fall investigation} in event of Fall or other adverse event:

- > Could this event have been prevented?
- > Were patient safety practices enforced?
- > What was the competency level of the staff nurses involved?
- > Did the staff have adequate staffing, supplies, and knowledge to prevent the event?
- > How was the case managed once the event was discovered?
- > Did everyone meet the standards of care?
- > What events led up to the event?
- > What was your role in the event, both expected and completed?



INCIDENT CHARTING

- **“Just the facts, ma’am”**
- (no assumptions!)
- Do not implicate anyone.
- Form is designed to obtain facts of event only.
- Any follow-up or investigation must be on a separate form.
- Must have follow-up monitoring policy in place.
- (after event, for how long do you assess—use pre-printed form).
- Timely process for signatures, etc.. process in facility.
- Notification of DN, Admin in timely manner prn.
- Exact times of notification



Post incident investigations.....

For legal and regulatory compliance and protection:

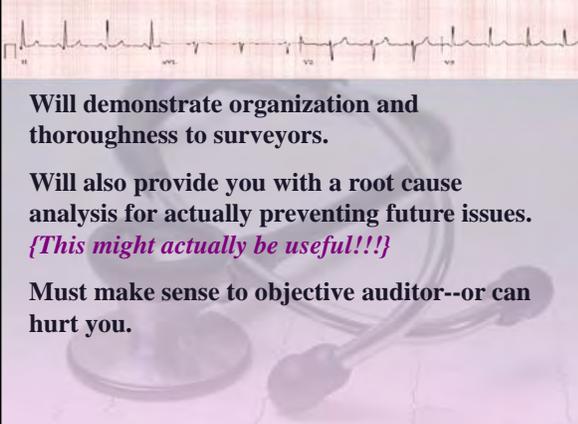
This is highly recommended, but tedious....

Goes above and beyond the incident report.

1. Place in colored files-color code (falls, skin tears, meds, etc)
2. Front-typed pg as summary....
3. Incident report.
4. Reportable forms
5. Post event assessment {form}-there are many.
6. Staff or witness statements-before, during, and after
7. Care Plan update, Nursing notes
8. Any other info, such as PT evals, etc...
9. Audit this file and use at Risk mtgs.

Investigation must flow: problem ID to resolution and correction.

Must make sense!



Will demonstrate organization and thoroughness to surveyors.

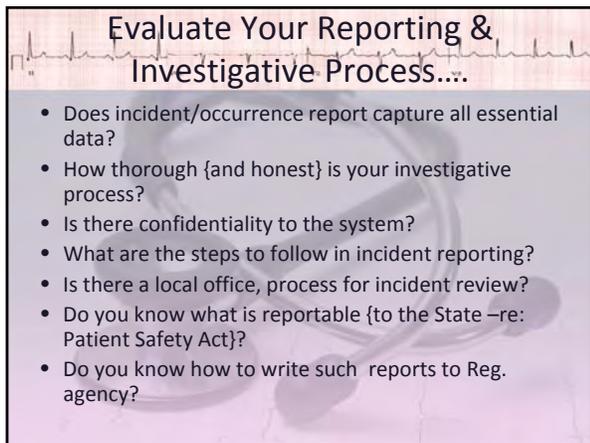
Will also provide you with a root cause analysis for actually preventing future issues.

{This might actually be useful!!!}

Must make sense to objective auditor--or can hurt you.

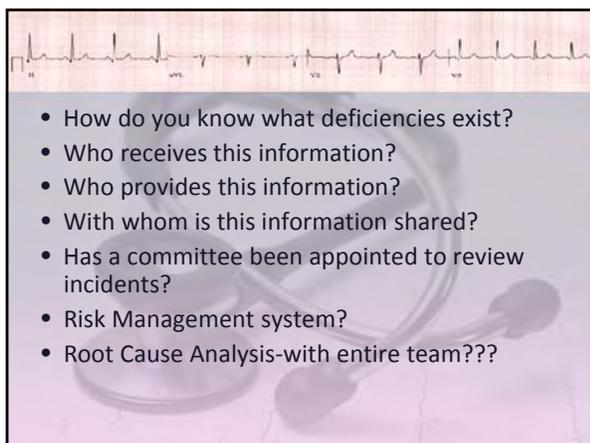


Focus on **Outcome** and **Follow-up**, evaluation in all areas.....



Evaluate Your Reporting & Investigative Process...

- Does incident/occurrence report capture all essential data?
- How thorough {and honest} is your investigative process?
- Is there confidentiality to the system?
- What are the steps to follow in incident reporting?
- Is there a local office, process for incident review?
- Do you know what is reportable {to the State –re: Patient Safety Act}?
- Do you know how to write such reports to Reg. agency?



- How do you know what deficiencies exist?
- Who receives this information?
- Who provides this information?
- With whom is this information shared?
- Has a committee been appointed to review incidents?
- Risk Management system?
- Root Cause Analysis-with entire team???

Your Role in Risk Management

- Employees are first line of defense
- Eyes and ears of the organization



“Whatever you do, don’t say, “OOPS!”

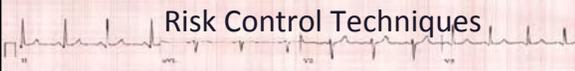
-Traditional advice passed down from doctors to their students before they try their first procedure.

Risk Identification

- Incident Reports
- Summons & Complaint
- Grapevine
- QA/QI Monitors/PI Cmtte
- Walking rounds/cmttees
- Community
- Media
- Regulators
- Complaints
- Industry Trends

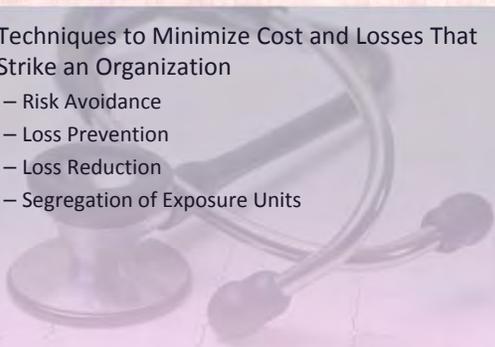
Risk Analysis

- Determine Frequency of Occurrence/Loss
- Determine Probable Severity
- Determine Possible Severity
- Determine Effect - Potential Loss on Organization
 - Financial & Operational
 - Subjective Opinions & Subjective Data



Risk Control Techniques

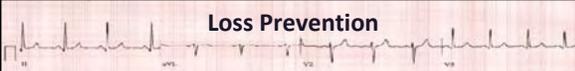
- Techniques to Minimize Cost and Losses That Strike an Organization
 - Risk Avoidance
 - Loss Prevention
 - Loss Reduction
 - Segregation of Exposure Units





Risk Avoidance

- Abandoning or Not Engaging in an Asset or Activity Rather Than Accepting the Associated Risk
- *The Only Risk Control Technique That Completely Eliminates the Possibility of Loss from a Given Exposure is to Choose Not to Engage in That Activity or Operation*



Loss Prevention

- Reducing or Eliminating the Chances of Loss
 - Examples
 - Surgical Instrument Counts
 - Carpeting Floors
 - Infection Control Procedures
 - **Safety Programs**
 - Credentialing
 - Effective Hiring and Screening
 - **Monitoring of Care**
 - **Fall teams/Clinical rev.**



Loss Reduction

- Reducing the Potential Severity of the Loss (Minimizing the Effect of Loss)
 - Examples
 - Team to Respond to Cardiac or Respiratory Distressed Patients
 - Sprinkler System
 - Disaster Plan
 - Crisis Management Team

BRIDGE THE GAP BETWEEN RISK & QUALITY

- GET A GRIP ON ORGANIZATIONAL USE OF QA AND QI DATA-Data usage alignment.
- FLOW CHART DATA-- USE AND ACCESS
- IDENTIFY NEED TO KNOW REQUIREMENTS
- Regular Quality Indic audits; rev P & Ps

COMMUNICATION

- Studies have proven that face to face communication with patients and their families and prompt reporting of complications and incidents **greatly diminishes the chances that you will be sued.** (Harvard, 1990...)
- Create relationships with pts/families.
- JC states that the biggest cause of errors, Adverse events is mis-communication or lack of among staff.

Document conversations with family, write letters of notification (high risk for wounds, falls).

Post-incident: meet with and explain, apologize.

Studies show that those facilities that have greater teamwork and communication among staff and with res/pts/families, along with pt. safety practices have less litigation and regulatory issues.

If Named in a Suit/Questioned by Surveyor

- Be prepared
- Be professional
- Be courteous
- Cooperate
- Be honest and truthful
- Do not blame others
- Do not alter records

“Gentlemen, it is better to have died as a small boy than to fumble this football.”-

*John Heisman (1869-1936)
Legendary football coach for whom the Heisman Trophy is named*

Some Memorable Fall Cases...

80 of LTC litigation has to do with falls and injuries:

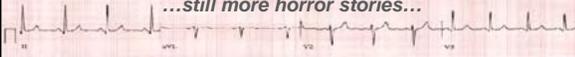
Vulnerability depends on:

- Proper assessment/reassessment
- Care planning that makes sense and is not a paper exercise!
- patient/resident/family teaching

ALF: Case: Family refused to have res go to SNF when level increased. Admin wrote 3 letter to family stating that they need to go to SNF. Pt. fell. Family sued. **The letter were very powerful. Family dropped suit!!**

Fall case (Levin & Perconti-Chicago): CP says “pommel cushion and bed/chair alarm.” Not in place when pt. fell, also left alone in DR. sustained sub-dural, died.

...still more horror stories...



Fall Case {defending} Hosp:
85 y/o alert, oriented woman, periods of confusion. Adm to hosp from ALF/hospital for rehab.
Has high risk for falls -done on daily basis and adm.
Dtr wants SR up. When she comes in they are always down. Told they can't use rails-"against law" Nrs dep says contrary.
Pt. fell broke hip. A lot of "failures" listed in complaint.
Named 2 nurses along with facility. {see next slide...}

Con't...



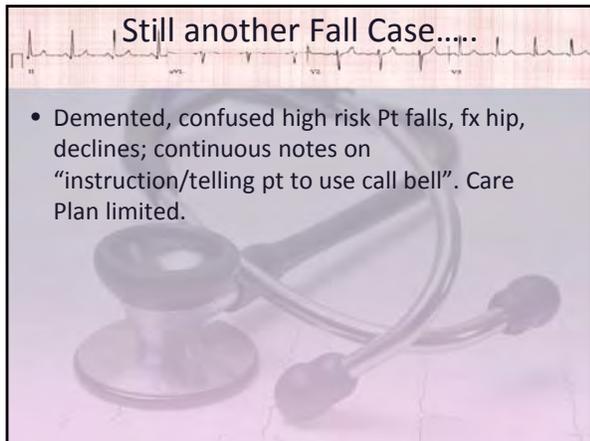
Assessed as high risk:
*No CP present, let alone for Falls.
*Tell her to use call bell, documented, yet doc that she is confused.
*Not toileted, on Lasix, on benzo. Also BP was low in am prior to fall, on anti HTN med.
*MD later said that the fall "was preventable" to dtr!!! (thanks for the help!}
*Issue of glasses/hearing aide-not provided to pt.
*No pt educ. **How to defend you???**



Fall/Hospital:
***Pt. post CVA, rt. Side weaknss/paralysis., left in WC after therapy, pushed out in hall.**
Pt. fell forward out of WC, damage to face, nose, bones.
Settled: Favor of Plaintiff
*Demented, confused high risk Pt falls, fx hip, declines; continuous notes on "instruction/telling pt to use call bell".
Care Plan limited.

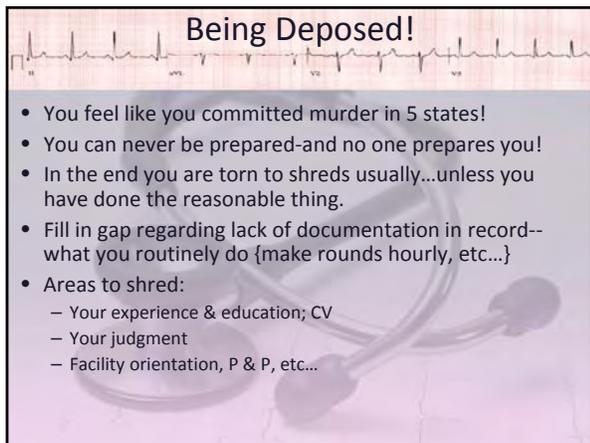
Still another Fall Case....

- Demented, confused high risk Pt falls, fx hip, declines; continuous notes on "instruction/telling pt to use call bell". Care Plan limited.



Being Deposed!

- You feel like you committed murder in 5 states!
- You can never be prepared-and no one prepares you!
- In the end you are torn to shreds usually...unless you have done the reasonable thing.
- Fill in gap regarding lack of documentation in record-- what you routinely do {make rounds hourly, etc...}
- Areas to shred:
 - Your experience & education; CV
 - Your judgment
 - Facility orientation, P & P, etc...



"Now this is not the end. It is not even the beginning of the end. But it is perhaps, the end of the beginning."
-Winston Churchill (1874-1965)

Be Proactive....

Not Reactive!

Learn from others' mistakes!

