LIABILITY
landscape

BY LINDA WILLIAMS, RN

Are your fall interventions enough?

It is estimated that as many as 75% of nursing home residents fall annually, twice the rate of seniors living in the community. Many of these falls are predictable because a single cause can be identified in about one-third of falls, whereas more than one risk factor will be involved in the rest. Intrinsic risk factors include:

- Cardiovascular problems (e.g., dysrhythmia, hypotension)
- Neurological problems (e.g., cardiovascular accident, Parkinson's disease, seizure disorder)
- Orthopedic problems (e.g., arthritis, status post–hip fracture, osteoporosis, osteomalacia)
- Sensory or perceptual deficits that include age-related vision or hearing changes, dizziness, and vertigo
- Normal aging changes in gait because of a loss of muscle mass and strength, including decreased limb coordination and inability to raise feet very high
- Psychological and cognitive factors, such as depression, apathy, delirium, and Alzheimer's disease or other dementia
- Medications, such as analgesics, anticonvulsants, antidepressants, antihypertensives, sedatives, anxiolytics, and antipsychotics
- Pain, fear of falling, sleep disorders, and incontinence

Extrinsic risk factors can be determined by assessing how a resident transfers to and from a bed or chair, ambulates, and uses bathroom handrails or other assistive devices, such as walkers or canes.

Because there are so many risk factors to consider, it is imperative for caregivers to quickly identify which ones pertain to the resident and then act on them to minimize a resident's potential for falling. Please review the following situation in which some caregivers thought they did all of the right things to minimize a resident's fall potential, yet later were accused of not doing enough. Plan to make changes as appropriate in your facility.

The Situation

An 88-year-old woman was admitted to a nursing facility for respite care on four different occasions during an 18-month period. The woman was frail and fell periodically when she was at home, as well as in the nursing facility. Subsequently, during each of the four admissions, the staff assessed and identified her as being at high risk for falls. They immediately implemented various fall precautions, such as using personal alarms, providing assistance when she was out of bed, and seeking therapy treatment to build up her strength and endurance when walking.

The administrative staff designated the building as being a "restraint-free" facility, so the nurses did not use any devices that would restrict the woman's freedom of movement or normal access to her body. This restraint-free designation was discussed in a pamphlet that was given to the woman's daughter during each admission process. Upon receiving the information, the daughter signed an acknowledgment that she had read, understood, and agreed with its contents.

Within three months of the woman's last admission to the facility, she began to fall more frequently, despite the staff's attempts to keep her safe. She suffered from chronic pain that could only be relieved with Vicodin, a narcotic analgesic medication with adverse effects such as drowsiness, dizziness, lightheadedness, and confusion. The woman had taken this medication for years and was given a daily therapeutic dose. Each time she fell, the nurses reported the incident to her physician, who refused to alter her medication regimen because the "benefits of pain relief outweighed the risk of falling." This rationale was verbally exchanged between the healthcare providers, but never documented or communicated to the woman's daughter.

One day, the nursing staff heard the woman's personal alarm sound, and when they entered her room they discovered her on the floor with a fractured leg. She was immediately sent to the hospital, where she was treated and released to a different nursing facility. She died three months later from congestive heart failure.

Later that year, the woman's daughter filed a wrongful death lawsuit against the facility and the physician, who was also the facility's medical director. The lawsuit alleged that both parties failed to take appropriate preventive measures to protect the woman from falling. The daughter asked for $275,000 to settle the matter.

In defense against these allegations, the facility hired a medical expert to review the woman's records and offer an opinion. The expert was a physician who specialized in internal medicine and geriatrics. After reviewing the information, the physician concluded that there was no negligence on behalf of the employees at the facility, as they had completed a fall risk assessment and used appropriate interventions (based on the assessment) to minimize the woman's risk of falling. The medical expert felt that the only possible way to have kept the woman from falling was for the family to hire a private sitter to stay with her around the clock.

Although the expert did not find fault with the facility's staff, he was quite critical of the woman's physician because he believed the Vicodin dramatically increased the woman's risk of falls. The expert felt that the physician should have known this risk and tried other pharmacological methods of controlling her pain. He added that the nursing staff could not be blamed for dispensing the Vicodin, as it was their job to inform the physician of the problem and to follow his orders, which they did.

Lastly, the expert determined there was no connection between the fracture and the

woman's death from congestive heart failure, therefore no causation. The daughter knew that the staff would not use restraints so, in essence, what could reasonably be done for the woman was done. After much deliberation, the lawsuit against the facility was settled for $23,000.

Safeguarding Your Residents and Facility

A common theme in claims lodged against nursing facilities after a resident is injured from a fall is that "the staff failed to take appropriate preventive measures to protect the resident from falling." The term "appropriate preventive measures" is a subjective statement without a clear or consistent definition by any two experts. Therefore, the best that caregivers can hope to do to avoid such allegations is to prove that they exercised the same degree of care that any other facility of ordinary prudence would have exercised under the same or similar circumstances. Unfortunately, the burden of proof lies heavily within the documentation of the clinical record, beginning with the risk assessment and implementation of interventions that are based on that assessment.

To safeguard your residents and facility, a fall risk assessment should be completed in all of the following circumstances: within 24 hours of admit, quarterly, with any significant change, and after any fall. Afterward, interventions should be implemented that are individualized according to the resident's needs. While interventions can be as simple as close observation and use of personal alarms, they also can include the following:

- Provide a bowel and bladder program. Cue or assist the resident to the bathroom every two hours and before/after activities and meals.
- Review medications. The resident's physician or pharmacist should evaluate if any medications associated with falls can be eliminated, reduced, or given at a more opportune time. He or she also should check for overlapping drug therapy, synergistic reactions, or the need for routine hypotension monitoring.
- Evaluate for acute illnesses that can increase restlessness (e.g., urinary tract infection, hypoxia, transient ischemic attacks).
- Evaluate assistive devices. All walkers, canes, wheelchairs, and other devices should be evaluated to ensure they are the appropriate type, height, and weight for the individual. The resident also should be evaluated to ensure he or she knows how to handle the devices and has the cognitive ability to use them correctly.
- Adjust environmental factors. Check the resident's footwear, keep pathways clear of clutter, lock brakes on beds/wheelchairs before transferring a resident, and make sure the toilet seat is low or high enough.
- Provide adequate nutrition, hydration, and supplements throughout the day as needed.
- Provide meaningful activities. Work with the activities department to find what interests the resident and keep items accessible near the nurses' station or in the room.
- Provide restorative care programs for walking, exercising, and strengthening. Keep the resident properly positioned in a bed, chair, and wheelchair.
- Use gait belts when assisting the resident with ambulation and transfers to minimize injuries if he or she begins to fall. Mechanical lifts should be used with residents that require extensive assistance. In-service training for staff should be provided that includes return demonstrations.
- Consult therapists. A physical or occupational therapist may need to evaluate the resident and make recommendations regarding positioning devices, restorative programs, or appropriateness for restraint use (e.g., wedge cushions).
- Answer call lights/alarms promptly. Always keep call lights within reach of the resident when in the room.
- Provide added supervision, as able. Seat the resident near the nurses' station during the day and encourage socialization. Alert staff to never leave the resident unsupervised when out of bed. Move the resident to a room closer to the nurses' station, if possible.
- Attach personal alarms to the resident's bed and wheelchair. If these are ineffective or the resident removes them, use sensor alarms.
- Plastic grips can be used to prevent the resident from sliding forward while seated in a wheelchair.
- Place tennis ball–type devices on the legs of the walker to facilitate a gliding movement rather than a jerking movement.
- Provide protective wear, such as elbow or knee pads and geri-hips.
- Consider an ambulation device to allow more independence.
- Consider lowering the resident's bed if he or she is anxious, confused, and unable to ask or wait for staff to assist with transfers.
- Consider placing all newly admitted residents on a fall prevention program for approximately one week until they are acclimated to their new surroundings.

Once a resident has been identified as being at risk for falling and interventions such as these have been implemented to minimize the risk, everything needs to be documented in the resident's chart and communicated to everyone involved with the resident's care. Don't forget to include interventions that the caregivers considered, but either chose not to implement or to discontinue, and state why. It also is helpful to keep a running log of interventions so the reader can see at a glance what was done or considered for the resident. By working together as a team, much can be accomplished to minimize a resident's risk of falling, as well as perceptions of "not doing enough." ■

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The GuideOne Center for Risk Management is dedicated to helping churches, senior living communities, and schools/colleges safeguard their communities by providing practical and timely training, and resources on safety, security, and risk management issues. For more information, phone (877) 448-4331, ext. 5175, e-mail slc@guideone.com, or visit www.guideone.com. *To send your comments to the author and editors, e-mail williams1007@nursinghomesmagazine.com.*