Long-Term Care Survey Alert

Fall Management: MAKE SURE YOUR FALL PROTOCOLS DONT FALL SHORT

Talk about double jeopardy. Surveyors not only hand out F tags for falls, they will cite your facility for inadequate follow-up of a resident's fall-related injuries.

The problem with falls, however, is that you can't always tell up front how serious a resident's injury might turn out to be and along with putting residents at risk, this can put your facility at the mercy of regulators, trial attorneys and even criminal prosecution.

"Symptoms of subdural hematomas, for example, may not show up for a day or two," cautions **Barbara Miltenberger**, a nurse attorney with the law firm of **Husch & Eppenberger** in Jefferson City, MO.

"There are too many falls with no apparent injuries that turn out to be significant," agrees **Dennis Stone**, chief medical officer for **HealthEssen-tials** in Louisville, KY, which provides long-term care facilities with nurse practitioners. "So we have our practitioner see the patient who falls that very day, if needed, or the next day."

Facilities should thus implement protocols for managing patients immediately after a fall, including a directive to contact the attending physician, or the medical director if the attending isn't responsive, Miltenberger suggests.

"The facility's fall protocol should also include directives for staff to contact the resident's family and to report the fall to the state as a sentinel or reportable event, suggests **Joseph Bianculli**, a health care attorney with **Bianculli & Impink** in Arlington, VA. "The facility also needs an appropriate clinical protocol including neurological checks and designating who is responsible for reporting a change in condition."

Report These Parameters

Miltenberger and other experts recommend facilities inform physicians of the following objective parameters:

1. Subjective complaints of pain appearing after the fall. "At HealthEssentials, we follow the old adage that an elderly white lady with pain in the hip has a fracture until proven otherwise," says Stone. "Also, any persistent pain should always be x-rayed."

2. The results of neurological checks.

3. Information about relevant medications the resident is taking, especially any form of blood thinner, such as aspirin, Coumadin or heparin. These drugs place the resident at high risk for intracranial bleeding from bumps on the head.

4. Pertinent medical history, such as seizure activity or clotting disorders.

"The facility policy should require the nurse to document in the nursing notes the specific information given to the physician," says Miltenberger. "It's then the physician's call as to whether a head scan is warranted." The physician evaluations and head imaging (CAT, MRI or PET) are separate from the facility's Medicare PPS rate.

Buck Stops With Facility

Don't be lulled by a physician saying the patient is OK after a fall, however, especially if you sense otherwise.

Bianculli reports a recent immediate jeopardy case where a facility called the physician after a resident fall. The physician came to the resident's bedside and pronounced her to be uninjured. "The woman died from a ruptured spleen the next night," Bianculli says. "However, the coroner can't tell if the spleen was injured from the fall, the CPR performed by staff when they found the patient unresponsive - or due to the patient's longstanding cirrhosis of the liver."

Even so, the facility got tagged with IJ and failure to report a change in condition. The lesson is, of course, that even if the physician gives the patient a clean bill of health after a fall, the facility should continue to monitor the resident following its own evidence-based protocol.

"The facility can, if necessary, send the patient to the emergency room, if it cannot obtain satisfactory medical evaluation or treatment" from the attending physician, says Bianculli.