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Long-Term Care Survey Alert

Quality Improvement: Check Out This Inside Secret To Risk Management And Survey Success

Hint: Don't miss seeing the forest for the trees - or the trees for the forest.

If you want to stave off survey and malpractice disasters, you have to target the "big ticket" liability risks - and hone in on the smaller "granddaddies" of all risks under the larger categories of adverse outcomes.

"Facilities can manage the majority of their liability risk by focusing on falls, pressure ulcers, physical and chemical restraints - and by managing acute issues 'acutely' and paying attention to their documentation," said **Mark Heard, MD, CMD**, a physician practicing geriatrics in Cumero, TX. Heard spoke on risk management at an Aug. 20 **American Medical Directors Association** conference in Nashville, TN.

However, to cover your bases completely, the quality assurance team needs to dig deeper within the major survey and liability hotbeds to ferret out the scenarios known to cause serious morbidity or death. Those are your immediate jeopardy citations and mega-million dollar lawsuits waiting to be written.

For example, while falls represent about 50 percent of malpractice claims in long-term care, only 11 percent of those who fall are
injured, said Heard. "So you want to try to identify the person who is ataxic or the most likely to be injured by a fall," he advised.

Case in point: Residents taking Coumadin and other anticoagulants are more likely to suffer a lethal subdural hematoma or other brain bleed from a fall where they hit their head. So facilities should plan to assess and monitor such residents closely when they have an unobserved fall where they could have hit their head, suggests **Clare Hendrick, RN, CRNP**, vice president of education and clinical development for **HealthEssentials Inc.** in San Clemente, CA.

Hip fractures caused by falls create a high probability of morbidity and mortality. To address that risk, **Bortz Healthcare of Traverse City** in Michigan puts residents at high risk for falls in hipsters, if they agree, which research shows reduces hip fracture, according to DON **Debra Hagerty, RN, MSN, MHA**. "Any reduction in risk of a hip fracture is positive," Hagerty tells **Eli**.

Hip protectors appear to be a cost-effective way to prevent osteoporosis-related hip fractures in elderly nursing home residents, according to Canadian research published in the August 2004 Journal of Rheumatology (read the abstract at www.jrheum.com/abstracts/abstracts04/1607.html).

Did you know? Bedrail-related accidents actually pose a much bigger threat of injuring or killing residents than do falls. "Among bedrail incidents that generate an incident report, 88 percent of residents are seriously harmed," Heard cautioned. That's why many facilities are foregoing bedrails or using them only as enablers to help residents improve their mobility, advises **Rich Blackburn, NHA**, principal of **ElderCare Risk Management** in St. Charles, IL

Safety tips: "If you're going to use bedrails, lower the resident's bed as far as possible and consider putting a rubber mat on the floor by the bed," advises Blackburn. To be on the safe side, "the facility really needs to do a careful individualized assessment to determine if a bedrail or other alternative would be safest for the resident," Blackburn adds.

Develop an Individualized Risk Profile

The resident's admission to the facility offers a major window of opportunity for identifying and preventing adverse events. And asking a few key questions can quickly flag residents at highest risk for suffering a fall, pressure ulcer, elopement or other negative outcome.

For example, if the resident fell often in his previous setting, you know he will fall in your facility, said **Cathy Ates, RN**, in a presentation on risk management at the June 2004 **National Association of Directors of Nursing Administration in Long-Term Care** in Orlando, FL.

By the same token, a resident who wandered off from his home or previous facility will likely wander off from your facility, Heard cautioned AMDA conference participants.

Remember: A resident who suffered a bad fall in the past may self-restrict his mobility, which is a major red flag for every negative outcome in the book, Hendrick cautions. "The biggest adverse effect of a previous fall can be a resident who is afraid to walk again," she says. "Immobility gets the ball rolling toward pressure ulcers, loss of strength, anorexia, weight loss, lack of participation in activities, incontinence, constipation, depression."

Know this statistic: "Eighty percent of pressure ulcers recur," cautioned Heard. "You'll think it's healed and walk in a few weeks later, and there it is again," he said. (The **National Pressure Ulcer Advisory Panel** recently announced that Stage 3 and 4 ulcers tend to recur because they alter the underlying architecture of the skin.)

"Staff should find out if a resident has a history of a previous ulcer, the location(s) and how the [wounds] were treated," advised **Sharon Roberson, RN**, a nurse consultant to the **Centers for Medicare & Medicaid Services'** Boston regional office, in a presentation during an Aug. 3 CMS surveyor training Webcast on the clinical care of pressure ulcers.

Try this: Consider implementing an "admissions unit" with assessment protocols for major issues like fall risk, pressure ulcers, elopement, etc., Hendrick suggests. "Assign your best assessors to do a risk profile on each resident during the admission transition, which takes about a week."

Admissions units that provide extra supervision for residents can also head off the number-one cause of falls: admission itself, adds Hendrick. A resident's greatest vulnerability for falls occurs within nine days or so after admission, according to studies Hendrick helped conduct for a major nursing home chain.

Act Before You See the F Tags

Address all of the identified risks before the resident develops a pressure ulcer or falls - or before a resident's existing decubiti or
other identified problem gets worse. For example, seek expert help early for residents with non-healing wounds. Many facilities refer patients to specialty wound clinics too late in the game, in Heard's experience. "[The referral] doesn't help six months later when the resident has multiple wounds the staff can't heal," he cautioned AMDA conference attendees. Facilities also need a good skin and wound care nurse to succeed with high-risk residents, Heard emphasized.

Consider this elopement risk management tip: One study showed that a contrasting, darker flooring around exits can help dissuade people with dementia from wandering out of the facility. The person with dementia apparently tends to perceive the darker-colored tile or carpet as a hole, according to information presented at the September 2004 **National Association of Subacute and Post Acute Care** in Washington.