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MDS Alert

Risk Management: Falls are Inevitable But Losing a Falls Case Doesn't Have to Be

Follow these tips to ward off potential liability following a resident fall.

More than half of nursing home residents fall each year, and about 11 percent of falls result in significant injury, notes **Randall Huss, MD, CMD**, medical director for **Rolla Manor Care Center** in Rolla, Missouri. "We all know that our residents fall, and about 40 percent fall repeatedly," Huss said at the "Nursing Facility Litigation and Liability: A Case-based Tutorial" session at the **AMDA**conference earlier this year.

Yet, there is an inherent assumption among plaintiffs that a fall is prima facie evidence that the nursing home has failed in its duty to provide adequate supervision, Huss notes. Plaintiffs are going to argue that the resident wouldn't have fallen if the nursing home had been doing its job in this regard, but you can't have somebody watching over each resident 24/7; that's just not possible," Huss says.

Document your residents' "successful falls"

The statutory definition of a fall is to go from a higher level to a lower level involuntarily, notes **David Smith, MD, CMD**, president of Geriatric Consultants of Central Texas, in Brownwood, Texas. "So a resident who rolls off the low bed onto the bedside mat has met the definition of fall. If a patient is walking with her therapist and she gets too tired and her knees buckle and the therapist lowers her to the ground, that's a fall. But these are what I call "successful falls," because the resident was not injured because the care plan was followed. It behooves providers to document these events as successful falls and that the current care plan is working," Smith explains.

Huss agrees. "We've introduced the concept of successful falls in my home, too. So, yes, Mrs. Jones was found on the floor. Yes, her alarms were going off. She's on the bedside mat but she's not injured. Well, the care plan is working. That's a successful fall."

In contrast: Unreported resident falls will increase your liability. "So many times when I hear about a resident falling, I go back to the nurses notes and there's nothing there. The falls were never reported to anyone. I just happened to hear about it from a staff member. You have got to document your residents' falls and your fall prevention measures that you put in place in the care plan," Huss emphasizes.

Follow your care plans for transfers

When a resident has a "near miss" fall, you may need to alter the care plan if appropriate, Huss notes. However, always make sure that you are following your care plans and make sure that you communicate care plan elements to your weekend and temporary staff, as well. "If the care plan says that you need two people to transfer this particular resident, then you'd better be using two people all of the time. If that resident falls during a transfer when there was only one staff member assisting, you are going to have a hard time defending yourself," Huss warns.

If, however, the resident really only needs one person to assist with the transfer, then change the care plan if it calls for a two-person assist. It is important to update your care plans to reflect changes in your resident's condition, for better or worse, Huss emphasizes.

Care plans that promise more than can be reasonably delivered increase your liability, Huss warns. "We often see goals like 'there will be no falls in the next 90 days,' but this is unreasonable. A better goal would be that you will minimize falls for the next 90 days, or prevent injuries from falls," he advises.

Be restrained in your use of restraints to prevent falls

Somewhat ironically, plaintiff's will often allege that a facility is liable for a resident's fall because they did not restrain the resident, Huss notes. "Nowadays, that claim seems silly, with our movement decades ago towards restraint-fee facilities. The literature now clearly shows that while restraints may reduce falls, they don't reduce falls with injury," Huss explains. (See the story, "When does CMS consider bed rails to be restraints?" on pg. 104.)

Huss recounts a tragic case where a nursing facility used a Velcro self-release seat belt to prevent a resident from getting out of her wheelchair and falling. The woman, who was suffering from DJD in her knees and dementia, began asking other residents and staff to release the belt, which resulted in numerous falls. "So they ordered a new wheelchair with an attached seatbelt and plastic clip closure. They called this a self-release belt, but the heavy plastic clip was difficult for even the staff to open. So she had this attached seat belt with basically an unopenable closure on it," Huss says.

Sad outcome: "One day the resident was found in her room, yelling for help. She had wriggled out under the seatbelt and was trapped up around her chest," Huss continued. The care plan was amended to keep the resident close to a supervised area while she was in the chair. However, one day she was left unattended in her room in her wheelchair and she once again tried to get out. Although she was able to ring the call light, by the time the CNA got there, the resident had slid further down and had basically strangled herself with the seat belt. She was cyanotic, not breathing and she expired.

There was no evidence that there was ever any re-evaluation of the appropriateness of that restraint or the need for a different restraint after that near miss event. The care plan was unchanged. The family sued the facility and physician for deviation of standard care and proper and safe use of restraints on the resident. Ultimately, the facility and physician settled the case for an undisclosed amount.

Lessons learned: Huss warns that the lessons of this case include that it is negligent not to use restraints appropriately with the proper safety precautions. "There was absence of appropriate policies or protocols for re-evaluation of the use of restraints. There was no policy or protocol that called for the facility to re-evaluate that restraint. And they didn't even follow their own care plan. After a near miss event you can't just say, "Phew, no injury happened here. Let's just keep doing the same old thing. You've got to re-evaluate your situation and the appropriateness of your interventions after a near miss event," Huss stresses.