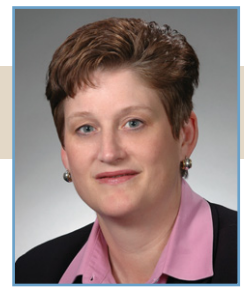
Legal Issues



By Janet K. Feldkamp, JD, RN, LNHA

Lessons From Nursing Facility Accidents

Accident hazards are among the most frequently cited deficiencies in long-term care facility surveys. Injuries resulting from accidents often lead to lawsuits against nursing facilities and the professionals there, and the result can be severe verdicts or out-of-court settlements that hurt monetarily and harm the facility's reputation.

As a result, nursing facility leaders, including the medical director, must be diligent in ensuring that all facility staff members are properly trained in both preventing accidents and responding to them. Accident prevention should be individualized to each resident and should be attended to all day, every day. An environment of safety awareness can enable facilities to prevent "avoidable" accidents.

Federal regulations require only that nursing facilities be as free from accident hazards as possible and that each resident receives "adequate supervision" and assistive devices that will prevent accidents. Tag F323 of the State Operations Manual, which gives guidance to state surveyors, indicates that surveyors should assess whether a facility adequately identifies hazards, analyzes them, implements interventions to reduce them, monitors these interventions for effectiveness, and modifies them when necessary.

Outlined below are two cases in which an accident led to a large verdict against a nursing home or a facility paid a significant out-of-court settlement. The patterns in these cases may serve as reminders of how facilities can prevent or respond to an accident.

Nine Falls, $1.16 Million Verdict

In 2006, a Georgia jury awarded $1.16 million to the estate of a deceased nursing home resident after it brought a wrongful death action against a nursing home.

The estate alleged that during the 1 year that the resident lived at the facility he fell nine times. One, a fall from his wheelchair, resulted in a hip fracture. However, staff didn't identify the injury for a week.

The resident then underwent hip-replacement surgery and, shortly afterward, fell from his bed when the side rails were not raised. This fall caused the resident's surgical incision to reopen, and the wound ultimately became infected, which resulted in severe circulatory problems. The resident's physician presented the resident's family with two choices: amputation of the leg and placement of a permanent feeding tube, or hospice care. The family chose hospice and the resident died within a few months.

Nevertheless, the estate brought a wrongful death action against the nursing home, arguing that the resident's death was caused by the staff's failure to clean the surgical wound properly and other negligence. The estate introduced evidence that the resident's wound was not cleaned for 4 days, during which it came in contact with urine and feces.

The nursing home attempted to defend against the action by arguing that the family's choice to place the resident on hospice care, rather than the nursing home's negligence, resulted in the resident's death. The facility asserted that residents received appropriate care. But the jury returned a verdict against the nursing home and awarded the money to the resident's estate.

In addition to failing to treat the resident's wound properly, the staff failed to follow safety precautions that could have prevented or mitigated the resident's injuries. First, had the staff properly assessed the resident's injuries after the fall from his wheelchair, the hip injury might have been mitigated. Second, had they used protective barriers on the resident's bed, the fall and its consequences probably could have been avoided.

Amputation, a $210,000 Verdict

In 2007, a Michigan jury awarded a nursing home resident $210,000 for the facility's negligence leading to a fall and amputation of the resident's right leg. She was a 90-year-old woman who suffered from a previous stroke, osteoarthritis, and Alzheimer's disease.

When a nurse's aide was transferring the resident from her bed to a chair, she ended up on the floor with her right leg bent under her left. Four nursing facility staff then used a lift to get the resident back into her bed.

Later, an x-ray revealed that the resident had suffered an oblique fracture of the distal femur in her right leg. Her physician recommended amputation of the leg above the knee because the resident's dementia would prevent her from participating in required postsurgical therapy.

The resident's leg was amputated, but later, the resident's daughter, acting on her mother's behalf, brought action against the nursing home to recover for depression, anxiety, and mental and physical suffering caused by the amputation. She alleged that the nurse's aide failed to use a gait belt when transferring the patient from the bed to the chair, despite the facility's policy requiring all employees to do so for all transfers.

The resident also alleged that the facility's staff exacerbated the injury by picking her up from the floor and placing her back in her bed before evaluating any damage to the leg. The nursing home denied negligence and claimed that the resident did not fall but was "lowered" to the floor after the resident's leg buckled and that the aide followed proper procedure. However, the jury found the nursing home negligent and awarded the resident $210,000 in damages.

Whether the nurse's aide in this case used a gait belt in the transfer was never established. However, nursing facilities should insist that staff members always use them during transfers. In addition, staff members should be taught to lift a fallen resident only after a nurse or a physician has fully evaluated the resident's condition and any possible injuries.

Lessons Learned

These are just two examples of poor outcomes when nursing facilities allegedly fail to establish or follow accident-prevention policies and procedures. In order to avoid similar situations, nursing home administrators and directors of nursing should ensure that all members of their staff are trained to identify and prevent potential accidents and to respond safely and effectively when one occurs.

Some practical tips:

- Develop a comprehensive accident-prevention program with involvement of your facility's Quality Assurance and Assessment Committee.
- Identify residents at increased risk of falls at admission and later in their stays through periodic reassessments.
- Develop individualized interventions based upon each resident's fall risk.
- Conduct ongoing and consistent implementation and monitoring of the resident interventions.
- Teach and regularly reinforce the accident-prevention program.
- Conduct a thorough investigation after each accident and send its findings through the Quality Assurance and Assessment Committee so it can improve the facility's accident-prevention program.

Developing a culture of safety for all employees will reduce a facility's risk of falls and other accidents as well as its risk of litigation and citations.

This column is not to be substituted for legal advice. The writer, JANET K. FELDKAMP, *practices in various aspects of health care, including long-term care survey and certification, certificate of need, health care acquisitions, physician and nurse practice, managed care and nursing related issues, and fraud and abuse. She is affiliated with Benesch Friedlander Coplan & Aronoff LLP of Columbus, Ohio.*

Medical-Expert Perspective

Clearly, not all falls can be prevented, but reasonable measures should be implemented with residents who are identified as being at risk. At the same time, such residents' rights and autonomy must be considered.

Constant supervision (such as the use of a "sitter") would prevent most falls, but this is not a viable option for most residents. Short of that, strategies include frequent visual checks, scheduled toileting, placing at-risk residents near nurses' stations, use of alarm devices, lowering beds, and using mattress pads as landing strips. All these should be considered before physical restraints.

Many facilities have gone to restraint-free policies. This is laudable and, when there is cooperation between facilities and families, workable. However, lawsuits have succeeded against such facilities after families have literally begged the nursing staff for more protection for a high-risk loved one and, after a fracture, found out that a nursing home right up the street would have used a belt or full side rails. Transfer to another facility needs to be discussed with such patients and families.

Care plans need to be individualized and updated frequently. Good postfall documentation needs to be performed. Physicians receiving calls from nursing homes about patients who suffer "noninjury" falls (or even near falls) should not ignore these as nuisances. These calls should, at the very least, prompt orders for an interdisciplinary team evaluation.

Every fall or near fall needs to be taken seriously, and many of them require action. Such consistent attention, as well as documentation of the thought processes that guide ongoing care, will demonstrate a vigilant and caring approach that will not only serve the resident, but will also reduce the risk of successful litigation.

—Karl Steinberg, MD, CMD
Editor in Chief