

## Legal Issues

By William C. Wilson, Esq



# Intervention and Documentation Reduce Exposure From Falls

Mr. N, age 79, was admitted to a skilled nursing facility for rehabilitation, assessed as having a high risk of falling.

During the first month of his residency, Mr. N fell nine times, usually when he tried to get out of bed to use the restroom. After each fall, an interdisciplinary

team conference was held and interventions were either added or adjusted.

After the sixth fall, padded pants were recommended, but Mr. N refused to

wear them. A bedside commode was discontinued because he refused to use it. After the seventh fall, Mr. N was noted to be “confused.” A wheelchair alarm was installed, and he was to be visually monitored around the clock. But his room was not visible from the nurses’ station.

The facility involved the primary care physician, and he declined to recommend any type of restraint. He discussed this with Mr. N and his wife, but these talks were not documented in detail.

One night, Mr. N’s bed alarm sounded. Staff reached his room approximately 2 minutes later and found him already using the toilet. While one nurse was shutting off the alarm, the charge nurse stood in the doorway. Nevertheless, Mr. N lost his balance and fell, his ninth fall, hitting his head on the wall. He underwent a craniotomy for a subdural hematoma and later suffered a stroke. He was readmitted to the facility for an expected 3 more months and fell two more times.

Mr. N sued the facility and the facility’s management company for elder neglect and violation of the patient’s rights. At trial, Mr. N, who suffered severe cognitive loss by this time, was awarded a multimillion dollar verdict, in part, due to the trial court’s admitting regulatory citations into evidence. The verdict was reversed on appeal, and a request for review to the California Supreme Court is pending. Mr. N died after the Court of Appeal reversed the jury verdict.

### Verify Informed Refusal

In Mr. N’s case, better documentation and attention to his plan might have significantly reduced the facility’s liability. Documentation of informed consent is the current darling of long-term care, at least in some jurisdictions. However, documentation of informed refusal is just as important, especially in an ambulatory, alert resident. In this case, a jury found conflicting evidence of whether restraints were discussed with either Mr. N or his family. There was also conflicting evidence as to whether or not Mr. N or the family refused restraints.

The facility had a form available for a resident to refuse restraints. However, it simply did not use it. This failure (even though restraints were inappropriate) was probably the key to the jury awarding significant damages.

It is significant that the physician attending to Mr. N did not order them. Unfortunately, this was not documented in detail. Clear documentation by the physician of the impropriety of restraints would have foreclosed the plaintiff attorney’s main argument for liability.

According to the Centers for Disease Control and Prevention (CDC), use of physical restraints does not lower the risk of falls or fall injuries and should

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### Solving Behavioral Problems With Hearts and Minds

*Susan Levy, MD, CMD, a Maryland-based medical director, talks about the importance of using non-drug treatments over medications whenever possible to address behavioral problems in people with dementia.*

When a person has advanced dementia, problem behaviors—screaming, cursing, hitting, etc.—are more common. You may think that drugs to calm the person are the best solution. However, we actually often can reduce, stop, or even prevent problem behaviors without drugs. We do this by finding out what is causing the behavior and changing the environment, routines, activities, etc. as needed. We also must consider the most common reasons that any person cries or acts out, such as hunger, pain, and fear.

Having an interdisciplinary team that shares common goals, information, and insights can help. For instance, a colleague recently told me about a nursing home resident with dementia who would spit, scream, and curse at staff trying to get her up in the morning. Then one nursing assistant said she learned from the woman’s family that she had owned a pet rabbit that would sleep with her. She wouldn’t get up until her pet was cared for. So the nursing assistant would pretend to pick up the rabbit, pet it, and put it on the floor before she got the resident up. As a result, she never had a problem with the woman.

Sometimes the solution is this simple. But it does require practitioners and staff to really know the resident. We need to talk with family members and friends when a person is admitted and then on a regular basis, especially when the person has a behavioral issue or a condition change. It also is helpful to have the same caregivers and staff working with residents so that they get to know each other and have trusting relationships.

Of course, antipsychotic medication sometimes is necessary. But there must be a clear goal for antipsychotic use. These drugs should be used only to address behaviors that present an immediate threat to the patient or others, or when the behaviors are causing the resident extreme distress (such as when the person thinks someone is trying to kill him or her). Even when these drugs are needed, they must be monitored carefully because they have some serious

side effects (such as tremors and the inability to sit still); and we need to reduce doses or stop the medication as soon as it is safe and appropriate to do so.

“Don’t prescribe antipsychotic medications for behavioral and psychological symptoms of dementia (BPSD) in individuals with dementia without an assessment for an underlying cause of the behavior” is one of AMDA’s recommendations as part of the American Board of Internal Medicine Foundation’s Choosing Wisely campaign. Choosing Wisely aims at identifying common health care practices and tests that lack scientific evidence to support their use. For more information, go to [www.choosingwisely.org](http://www.choosingwisely.org).

#### ► Questions to Ask Your Physician:

- How can I get more involved in this person’s care and activities?
- What should I do if I notice that he or she is upset or agitated?
- If my family member or friend must take antipsychotic medications, what side effects or adverse reactions should I watch for?
- What will happen when my family member or friend has a behavioral issue or acts inappropriately?

#### ► What You Can Do:

- Share information about the person’s life, habits, and routines that might help staff care for him or her.
- Make sure staff know about any special fears or pet peeves (such as fear of dogs or dislike of cold weather) your family member or friend has.

#### ► For More Information:

- Long-Term Care Prescribing of Antipsychotic Medication: [www.amda.com/governance/resolutions/E12.cfm](http://www.amda.com/governance/resolutions/E12.cfm)
- Improving Dementia Care and Reducing Unnecessary Use of Antipsychotic Medications in Nursing Homes: [http://doh.sd.gov/news/documents/cms\\_dementia\\_care.pdf](http://doh.sd.gov/news/documents/cms_dementia_care.pdf)

not be used as a fall prevention strategy. Some researchers have found that restraints “can actually increase the risk of fall-related injuries and deaths,” according to the CDC.

### Practical Challenges

Appropriate and accurate assessment of a patient’s fall risk is a critical step to preventing falls. Besides the mandatory Minimum Data Set assessment of each resident, facilities should perform an initial “quick” assessment of each resident’s fall risk. This snapshot assessment should note a history of falls; cognition, including fluctuating mental status; impulsivity; vision; ambulation; continence; use of high-risk medications (e.g., antihypertensives, diuretics, narcotics, sedatives, and hypoglycemics); use of assistive devices for transfer or ambulation; attached equipment (e.g., catheters, intravenous lines, and oxygen); familiarity with the environment.

Use this (or a similar) initial risk assessment to create a fall-prevention care plan for each resident. Then review and possibly revise the plan at least every 3 months or after any fall. From an attorney’s perspective, all too often care plans are created and then ignored.

After Mr. N’s first fall, the facility assessed him and found him to have poor safety awareness and an unsteady gait. Also noted were his attempts to function beyond his ability, including when he repeatedly climbed out of his bed or chair. The facility’s interdisciplinary team recommended placing his bed in the lowest position, implementing a toileting program, and regularly reviewing his drug regimen.

Ideally, the care plan would have been updated and the interventions implemented and documented in a way that reflected not only the revised plan, but also nurses’ progress notes, team notes, relevant pharmacist communications, and physician’s notes.

The medical chart also should have reflected discussions that facility staff had with the resident, when alert, and Mr. N’s representative. Other family communications should have been detailed. Too often such notes say something like “family made aware,” which does not communicate to the end reader (usually an attorney) what was advised and whether or not the family agreed.

After Mr. N’s sixth fall, he was not moved to a room that was visible from the nurses’ station. Although making the common sense move to a room by the nurses’ station would not have guaranteed immunity from liability, it would have shown that the facility was being proactive in Mr. N’s care.

### Interventions

CDC recommendations include:

- ▶ Assessing patients after a fall to identify and address risk factors and underlying medical conditions.
- ▶ Educating staff about fall risk factors and prevention strategies.
- ▶ Reviewing prescribed medicines to assess their potential risks and benefits and to minimize use.
- ▶ Making changes in the nursing home environment to make it easier for

residents to move around safely. Such changes include putting in grab bars, adding raised toilet seats, lowering bed heights, and installing handrails in the hallways.

- ▶ Providing patients with hip pads (although evidence for this is weak).
- ▶ Providing exercise programs that can improve balance, strength, walking ability, and physical functioning among nursing home residents.
- ▶ Perhaps, providing vitamin D supplementation.
- ▶ Teaching residents behavioral strategies to avoid hazardous situations.

Accurate assessment, documentation, and follow-up are keys to preventing falls. Common sense is also important: Keep the family informed. If they refuse medical recommendations on behalf of a resident, document this multiple times in the medical chart. Report changes of condition to the resident’s attending physician and update care plans as necessary.

Of course, it is impossible to prevent all falls of ambulatory residents, but they can be minimized. Most important from a physician’s perspective is to educate an impaired resident’s family that restraints are probably inappropriate and that the

patient may fall. Detailed documentation of these conversations is important to establish that the health care team is doing what it can to address the patient’s risk of falling.

*This column is not to be substituted for legal advice. WILLIAM C. WILSON is a partner in the law firm Wilson Getty LLP, which represents all types of long-term care facilities against civil claims. He also represents facilities in administrative hearings and advises long-term care clients on risk management and corporate compliance.*