Dear Dr. Jeff:

I believe that our medical staff is providing top quality medical care to our residents, but I have major concerns about the integrity of other disciplines in our facility. Residents develop injuries that are accepted as “accidents” but seem hard to explain. I am not sure that any of this is, strictly speaking, my responsibility or that there is anything I could do. What do you suggest?

Dr. Jeff responds: Medical practitioners in long-term care are expected to be part of an interdisciplinary team. Although most discussions on this topic—including several in past columns—are designed to convince physicians and other clinicians of the benefits to patients when other team members have input to care plans, this should clearly be a two-way street. Everything having to do with the care of residents is indeed the attending physicians’ business and responsibility.

Those who expect physicians to listen to their ideas and observations must equally be willing to address clinicians’ concerns. The medical director should review trends within the building, including particular times or geographic locations with high injury rates; suspicious patterns of accidents, such as multiple wheelchair-related injuries; and individual occurrences, recognizing that the medical director cannot be familiar with the medical details of every resident.

First, however, some cautions. Frail elders are at risk for a variety of traumatic injuries. The very conditions that lead to nursing home placement, such as cognitive impairment with poor judgment, Parkinsonism with impaired balance, focal weakness from prior strokes, osteoporosis with prior fractures, peripheral neuropathies, orthostatic hypotension (often exacerbated by medications for hypertension and congestive heart failure), urinary incontinence, and impaired vision and hearing, are all risk factors for falls and injuries. Psychotropic medications, particularly antidepressants, also increase the risk of falls.

Since elders healthy enough to live in their communities fall about once a year, it should be no surprise that nursing home residents sustain high rates of falls and injuries. Identification of residents “at risk” for falls has not been an effective way to actually reduce falls, since practically every new admission can earn that label. Even the best fall-prevention program will not eliminate the majority of injuries.

Also, thinning of the dermis, loss of elastic tissue in the skin, and fragility of small blood vessels are all aspects of normal aging and leave the elderly particularly susceptible to bruising. Anticoagulant medications and skin damage associated with ultraviolet light exposure exacerbate this tendency. As a result, many nursing home residents have a condition called senile purpura, in which reddish-to-purple areas (variably identified as purpura or ecchymoses) occur spontaneously or with minimal trauma. These non-tender lesions are found primarily on the arms, the back of the hands, or the lower legs.

These are not the result of “accidents,” but rather the signs of a chronic skin condition. Yet nursing staff often label them as “bruises” and produce accident reports when they occur. Minimal trauma to fragile skin can also produce skin tears. These superficial injuries may bleed, but are rarely painful and rarely reflect mistreatment.

In these cases, coagulation testing is not necessary. Since these conditions are generally bilateral, the presence of “bruises” on both arms should not necessarily lead to suspicions of abuse.

When to Investigate

Facilities are required to notify the attending physician whenever an incident occurs. Often, this comes in the form of an answering service message without any response obviously expected. However, every episode labeled as an accident should be reviewed not only by the attending physician or other clinician but also by the medical director. Often, a fall, even without injury, is actually a marker for a change in condition.

Worsened cardiac or pulmonary conditions may leave a resident too weak to walk the distance that they usually handle without difficulty. A new infection, such as a pneumonia that might present in an elderly patient without significant cough or fever, could certainly cause weakness and yield a fall. Similarly, anemia, dehydration, or an electrolyte imbalance can produce falls.

For these reasons, all falls or injuries should be evaluated for the possibility that they signal the need to modify a care plan. But they may reflect a failure of care systems: a resident’s needs not communicated to direct-care staff, equipment failure, or, worst case, actual malfeasance by members of the health care team within the facility. The evaluation of a resident who has sustained a new fall or injury is clearly medically necessary and, as such, reimbursable by insurance carriers.

Certain events should raise red flags. These include episodes in which a resident would be unable to get up off the floor independently as described as “found in bed” with an injury that could only have occurred from a fall. This suggests that a staff member or members assisted the resident back into bed, pointing to an attempt to cover up an absence from the unit or involvement in an unauthorized activity. Similarly, a resident who is unable to roll over should not be “found on the floor.” Unless the resident is able to give a reasonable description of how the episode occurred, such incidents suggest possible abuse or neglect.

A routine fall, absent an underlying skin condition, usually will not produce injuries on both sides of the body. Bilateral injuries, regardless of severity, suggest abuse. Similarly, certain injury configurations, such as bruises with sharp demarcations in suspicious configurations or location, such as the shape of a belt buckle or involving the genitalia, are highly suspicious. A pattern of frequent falls in one physical location or recurrent episodes involving one resident or one care assignment should certainly raise suspicion.

Unfortunately, it is not unusual for nurses to be reluctant to report nursing assistants or housekeepers with whom they might have to work in the future. If staff members are not convinced that administration will back them, they may be frightened to report others whom they suspect are abusing residents. Regardless of the offender’s relationship to management, or the ownership structure, only a zero-tolerance policy will convince frontline staff that they will receive needed support, particularly because staff members who threaten residents may also threaten violence against their fellow employees.

How to Investigate

No facility is immune to occurrences of abuse or neglect. They are not confined to third-rate facilities. Neither five stars on a government website nor a deficiency-free state survey is a guarantee against the occasional rotten apple in the barrel.

Suspicion is certainly increased if the resident evidences fear of direct care by one or more staff members. Occasionally, new and unexplained injuries are caused by a new medical problem, as when bilateral bruising has been caused by seizure activity or extensive ecchymoses from new coagulopathy. But even these unusual circumstances will generally be identified only when the medical staff directly investigate the occurrence.

Every incident investigation should include asking the resident to explain the episode. Although paraemia can be a behavioral complication of dementia, resident accusations should not be dismissed out of hand. Residents with significant cognitive impairment are at the highest risk of abuse. The possibility must, unfortunately, be included in the differential diagnosis of “agitation” or “calling out.”

Directors of nursing and administrators are sometimes reluctant to investigate suspicious injuries or patterns of injury. This reluctance, essentially an eagerness to “sweep bad things under the rug,” has multiple causes. Topping the list would be a fear of litigation, followed closely by fear of deficiency citations. There may also be some reluctance to deal with a generally good employee who “had a bad day” or the possible loss of an employee in a community where staff recruitment may be difficult.

Misplaced loyalty to the facility clearly sends the wrong message to other staff. Equally importantly, when discovered, it produces greater liability for the facility and creates the probability that the senior staff members will have their licenses removed, be subjected to criminal prosecution, or both. Most severe disciplinary actions or license removals for senior long-term care staff arise from administrators or directors of nursing trying to cover up an incident. Although legal requirements for physicians to report suspected elder abuse vary from state to state, there is no state where administrators are not required to report such a case. We all share an obligation to protect frail elders in our care.

Everyone’s primary loyalty in a nursing home must always be to our patients. This means ensuring that systems within the facility are designed to protect our residents and that they actually do. No one should ever be reluctant or afraid to speak up for our residents.

For you to speak out, you first must discuss the injury incident with other members of the interdisciplinary team. If this does not resolve your concerns, it is necessary to go to the administration. Ultimately, if these people are unwilling to do what is needed to protect residents, your obligation is to go to the appropriate regulatory agencies or legal authorities. As a health care professional, you have no choice. Anything short of this means that you are not providing top-quality medical care.

Dr. Nichols is president of the New York Medical Directors Association and a member of the CARING FOR THE AGES Editorial Advisory Board. Comment on this and other columns at www.caringfortheages.com under “Views.”