Dear Dr. Jeff:  

The nursing home asks me to countersign every report of an “accident” or “incident.” I am told that this is a code requirement, although this makes no sense to me. I can’t find it in the F301 code section that describes the duties of the medical director. And, although I am extremely proficient at signing my name, I don’t see how this process enhances resident care. What do you think?

Dr. Jeff replies:  

Of course there is no purpose served in signing forms that you have not reviewed. You also are correct that physician review of accidents and incidents, as such, is not a federal requirement. And when review consists primarily of signing forms, it is certainly not even a best practice.

However, the review of accidents and incidents, when performed thoughtfully and as part of an overall quality improvement process, can be a mechanism to improve facility processes, enhance safety, and even identify potential episodes of resident abuse or neglect.

Most health care facilities in the United States prepare reports when a patient experiences an unexpected injury, or when marked deviations from usual care practice occur. These have primarily been used for risk management rather than clinical purposes. Pressure ulcers and falls with injury are the two most common triggers for litigation against nursing homes. Consequently, facilities try to demonstrate that these unfortunate outcomes were unavoidable. In nursing homes, where regulations require formal reporting of any episode of resident abuse or neglect (including resident-to-resident abuse), these reports also are used as a mechanism to investigate potential abuse. In many facilities, the forms include facility documentation of the investigation regarding potential abuse and whether a report must be made. Statements from involved staff are often attached to demonstrate that the episode was reviewed carefully, even when the statements all confirm that an event was uneventful.

Read Carefully  

Two portions of accident reports are worth reading carefully. The first is the resident’s own description of the episode. All too often that portion is left blank or asserts that the resident was unable to give an account. Although some residents are truly unable to speak or are too confused to answer a description of the event, an investigation of abuse or neglect should start there. If the resident has fallen on the way to the toilet (perhaps the most common accident in nursing homes and with frail seniors in the community), did the resident try to call for assistance with this task before attempting it on his or her own, and, if so, how long did he or she wait? If a resident needed to reach a toilet and the call wasn’t answered within a reasonable time — and opinions may vary as to how long a wait with a full bladder is reasonable — was that fall truly an accident? Obviously, if the resident describes something sounding like abuse or neglect, that requires immediate attention.

The second portion of the report that should be reviewed is the description of the actual injury. When the occurrence being investigated is a new bruise, obviously the resident’s account of the episode is still important, but many frail seniors will bruise without major trauma, even when not taking blood thinners.

Patients with senile purpura develop extensive areas of skin discoloration with minimal trauma due to extravasation of blood from fragile blood vessels under the skin, with a possible outcome of an unexpected falls. However, a quick review should confirm that the injuries described are consistent with a benign explanation. Ecchymoses (black and blue marks) over the body can be from attempts to draw blood for laboratory tests, and could even be bilateral. But a row of bruises on each arm may suggest finger marks from excessive pressure used to grip the arms. Injuries on one side of the body could be sustained if a resident rolls out of bed. But bilateral injuries to the face or limbs are not consistent with that explanation or most benign explanations, except perhaps seizure activity. Bilateral facial bruising is particularly suspicious for abuse.

When unexplained injuries are found on residents who are unable to transfer in and out of bed by themselves, witness accounts denying an observed fall should be taken with a grain of salt. Even if the resident had somehow wiggled out of bed and landed on the floor, they would have been unable to put themselves back into the bed unassisted. However, osteoporotic fractures can occur during routine bedbound care. These are typically nondisplaced spiral fractures of the mid-shaft of long bones. They may occur while simply rolling a patient from side to side in bed and are seen in bones of residents who have been non-weight bearing for prolonged periods, usually for a year or longer. Moreover, common fractures of the shoulder, wrist, knee, or ankle generally cannot be explained by osteoporosis alone.

Review of individual reports rarely provides significant information to guide a quality improvement process. Simply quantifying the number of reports and comparing the total from month to month is a futile exercise. If the number decreases, what was done right? Should a good month lead to pizza parties and a bad month lead to super- cuisine or trigger a search for a root cause? Some units will excel in one month and decline in another. If care processes don’t change, tracking statistics is simply monitoring random variations or a changing patient population.

Sort Falls by Type  

At a minimum, accidents should be sorted by type. If the facility has identified fall reduction as a target for quality improvement, these should be separated out. Although a facility may differentiate falls producing injury from other falls, it is not clear that they truly represent a different process, as opposed to a lucky vs. unlucky fall. Residents who are “eased to the floor” should probably be included, however, because presumably a fall-inducing process was present here, even if the staff deserves kudos for a rapid intervention.

Although it may be useful to analyze falls by unit or shift, this data should be reviewed in context. Residents on PA units are typically more cognitively intact and are receiving restorative therapies, yet they usually have higher fall rates than those on long stay units. Although the explanation for this apparent contradiction is not clear, it may be due to their new environment, recent changes in functional level, and their belief that they can do activities on their own that they have performed in the rehab department. Falls that occur on the 3–11 p.m. shift may have resident fatigue as a contributing factor, whereas falls between 11 p.m. and 7 a.m. are frequently related to nocturnal toileting requirements, orthostatic hypotension, and the contribution of various medications to hypotension and impaired balance.

Tailored Prevention Programs  

Facility fall prevention programs must be individualized to the facility, and adjusted to its needs and resources. The literature regarding fall prevention is extensive, while a huge number of interventions for which negative results were never published have been discarded. Most programs concentrate on one or more of three major areas: environmental modifications, medication management, and programs to support physical activity and improve balance. Many facilities incorporate elements of all three into an overall fall prevention program. Although multiple interventions initiated simultaneously may make it difficult to determine which components are effective, there also is considerable support for the notion that multiple small impacts can have a multiplier effect on outcomes. Tracking falls through accident data can help demonstrate whether your program is effective, and possibly which aspects are most effective.

Although environmental concerns such as wet floors are typically addressed directly on accident and incident reports (the nursing home equivalent of loose throw rugs), issues such as ambient lighting rarely are, since lighting levels are often assumed to be adequate. Yet impaired visual acuity is common in nursing home residents; darkened rooms are not unusual, and hinder the resident’s ability to navigate barriers in the room or see debris on the floor. Environmental concerns should be broadened to include the total environment of care. Many facilities have reported that routine nursing rounds anticipate needs before they become critical and induce unsafe behaviors. Scheduled toileting regimens may help reduce falls as well as decrease uri- ninary incontinence.

Screening regimens to identify at-risk residents are an option. Declining function should be a trigger for restorative rehabilitation or intensified floor nursing rehabilitation programs. Improving balance and general strength should have obvious direct impact on fall numbers. Programs such as tai chi or other balance exercises could be initiated by different departments. To best assess risk, strength and balance ideally should be evaluated in late afternoon, when the resident is likely to be tired.

Medication management and reduction programs have been shown in multiple studies to decrease fall rates. While reducing some low-hanging fruit such as sedative/hypnotics or nocturnal doses of diuretics is a good start, general reductions in polypharmacy may also have benefits. Long lists of medications have been associated with orthostatic hypotension, falls, or both. Because of drug-drug interactions, even seemingly benign medications still may increase risk.

Sometimes an accident is just an accident. And sometimes, it is an opportunity to improve care.

Dr. Nichols is president of the New York Medical Directors Association and a member of the Caring for the Ages Editorial Advisory Board. Read this and other columns at www.caringfortheages.com under “Columns.”