Patient Falls in Hospitals and Nursing Homes: A Safety Challenge

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Fall and injury prevention continues to be a considerable challenge in all health care areas, as well as in the homes of those at risk. Inpatient fall prevention has been an individual area of concern for nursing for almost 55 years. Falls in such settings are treated as adverse events, with inpatient fall rates ranging from 1.7 to 25 falls per 1,000 patient days, depending on the care area. Fall statistics indicate that the overall risk of a patient falling in the acute care setting is approximately 1.9 to 3% for all hospitalizations. The average fall rate in medical surgical units is generally 2.5 to 3.5 {per 1,000 patient days}{Toledo…..}. AHRQ {Agency for Healthcare Quality} states 3.7 per 1000 patient days for acute in patient {hospital}.CMS {Centers for Medicaid and Medicare} and most state departments of health require mandatory reporting of falls with injury. In 2008, CMS mandated no payment to facilities where a fall results in a fracture or moderate to severe injury, extending length of stay or causing death.

There is much literature on this topic. The focus here is to discuss the standards of care and regulations pertaining to fall prevention.

The OBRA Regulations, which are those Federal regulations that apply to nursing homes in the United States, are as follows specific to falls. "Patient Rights, Dignity" standards may also apply as well as some others, depending on the patient status. "Probes" refers to review criteria that the Surveyor utilizes in the investigation.

F323

§483.25(h) Accidents
The facility must ensure that --
§483.25(h)(1) The resident environment remains as free of accident hazards as is possible; and
Intent §483.25(h)(1)
The intent of this provision is that the facility prevents accidents by providing an environment that is free from hazards over which the facility has control.
Interpretive Guidelines §483.25(h)(1)
This corresponds to MDS version 2.0 section J, when specified for use by the State.
"**Accident hazards**" are defined as physical features in the NF environment that can endanger a resident's safety, including but not limited to:
• Physical restraints (see physical restraints §483.13);
• Equipment or devices that are defective, poorly maintained, or not used in accordance with manufacturer's specifications (e.g., wheelchairs or geri-chairs with nonworking brakes, and loose nuts and bolts on walkers);
• Bathing facilities that do not have nonslip surfaces;
• Hazards (e.g., electrical appliances with frayed wires, cleaning supplies easily

accessible to cognitively impaired residents, wet floors that are not obviously labeled and to which access is not blocked);
• Defective or improperly latched side rails or spaces within side rails, between upper and lower rails, between rails and the mattress, between side rails and the bed frame, or spaces between side rails and the head or foot board of the bed that can entrap limbs, neck or thorax, and can cause injury or death;
• Handrails not securely fixed to the wall, difficult to grasp, and/or with sharp edges/splinters; and
• Water temperatures in hand sinks or bath tubs which can scald or harm residents.

Probes: §483.25(h)(1)

(See F221 for guidance concerning the use of bedrails.) See also §483.70(h), Safe Environment.

F324

§483.25(h)(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Intent §483.25(h)(2)

The intent of this provision is that the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents.
An "**accident**" is an unexpected, unintended event that can cause a resident bodily injury. It does not include adverse outcomes associated as a direct consequence of treatment or care, (e.g., drug side effects or reactions).

Procedures §483.25(h)(2)

• If a resident(s) selected for a comprehensive or focused review has had an accident, review the facility's investigation of that accident and their response to prevent the accident from recurring.
• Identify if the resident triggers RAPs for falls, cognitive loss/dementia, physical restraints, and psychotropic drug use and whether the RAPs were used to assess causal factors for decline or lack of improvement.
• If the survey team identifies a number of or pattern of accidents, in Phase II sampling, review the quality assurance activities of the facility to determine the facility's response to accidents.

Probes: §483.25(h)(2):

1. Are there a number of accidents or injuries of a specific type or on any specific shift (e.g., falls, skin injuries)?
2. Are residents who smoke properly supervised and monitored?
3. If the survey team identifies residents repeatedly involved in accidents or sampled residents who have had an accident:

a. Is the resident assessed for being at risk for falls?

b. What care-planning and implementation is the facility doing to prevent accidents and falls for those residents identified at risk?
c. How did the facility fit, and monitor, the use of that resident's assistive devices?
d. How were drugs that may cause postural hypotension, dizziness, or visual changes monitored?

Many Attorneys feel that to prevent falls, that restraints must be used. Again, depending on the indication and status of the patient, restraints may be indicated. They are not absolutely prohibited, but must be specifically indicated, ordered on a regular basis, and reassessment of the patient is to be done on a routine prescribed basis as well as monitoring for safety. The following are again, taken from the OBRA Regulations:

§483.13 Resident Behavior and Facility Practices

F221
Use Tag F221 for deficiencies concerning **physical** restraints.
USE GUIDANCE UNDER TAG F222

F222
Use Tag F222 for deficiencies concerning **chemical** restraints.

§483.13(a) Restraints
The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.
Intent §483.13(a)
The intent of this requirement is for each person to attain and maintain his/her highest practicable well-being in an environment that prohibits the use of restraints for discipline or convenience and limits restraint use to circumstances in which the resident has medical symptoms that warrant the use of restraints.

Interpretive Guidelines §483.13(a)
Definitions of Terms
"Physical Restraints" are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
"Chemical Restraints" is defined as any drug that is used for discipline or convenience and not required to treat medical symptoms.
"Discipline" is defined as any action taken by the facility for the purpose of punishing or penalizing residents.

"Convenience" is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest.
"Medical Symptom" is defined as an indication or characteristic of a physical or psychological condition.
"Convenience" is defined as any action taken by the facility to control a resident's behavior or manage a resident's behavior with a lesser amount of effort by the facility and not in the resident's best interest.
Restraints may not be used for staff convenience. However, if the resident needs emergency care, restraints may be used for brief periods to permit medical treatment to proceed unless the facility has a notice indicating that the resident has previously made a valid refusal of the treatment in question. If a resident's unanticipated violent or aggressive behavior places him/her or others in imminent danger, the resident does not have the right to refuse the use of restraints. In this situation, the use of restraints is a measure of last resort to protect the safety of the resident or others and must not extend beyond the immediate episode. The resident's right to participate in care planning and the right to refuse treatment are addressed at §§483.20(k)(2)(ii) and 483.10(b)(4), respectively, and include the right to accept or refuse restraints.
Physical Restraints are defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body.
"Physical restraints" include, but are not limited to, leg restraints, arm restraints, hand mitts, soft ties or vests, lap cushions, and lap trays the resident cannot remove easily. Also included as restraints are facility practices that meet the definition of a restraint, such as:
• Using side rails that keep a resident from voluntarily getting out of bed;
• Tucking in or using velcro to hold a sheet, fabric, or clothing tightly so that a resident's movement is restricted;
• Using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident cannot remove easily, that prevent the resident from rising;
• Placing a resident in a chair that prevents a resident from rising; and
• Placing a chair or bed so close to a wall that the wall prevents the resident from rising out of the chair or voluntarily getting out of bed.
Side rails sometimes restrain residents. The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Residents who attempt to exit a bed through, between, over or around side rails are at risk of injury or death. The potential for serious injury is more likely from a fall from a bed with raised side rails than from a fall from a bed where side rails are not used. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to

transfer from the bed.

As with other restraints, for residents who are restrained by side rails, it is expected that the process facilities employ to reduce the use of side rails as restraints is systematic and gradual to ensure the resident's safety while treating the resident's medical symptom.

The same device may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another.

Orthotic body devices may be used solely for therapeutic purposes to improve the overall functional capacity of the resident.

An enclosed framed wheeled walker, with or without a posterior seat, would not meet the definition of a restraint if the resident could easily open the front gate and exit the device. If the resident cannot open the front gate (due to cognitive or physical limitations that prevent him or her from exiting the device or because the device has been altered to prevent the resident from exiting the device), the enclosed framed wheeled walker would meet the definition of a restraint since the device would restrict the resident's freedom of movement (e.g. transferring to another chair, to the commode, or into the bed). The decision on whether framed wheeled walkers are a restraint must be made on an individual basis.

"Medical Symptom" is defined as an indication or characteristic of a physical or psychological condition.

The resident's medical symptoms should not be viewed in isolation, rather the symptoms should be viewed in the context of the resident's condition, circumstances and environment. Objective findings derived from clinical evaluation and the resident's subjective symptoms should be considered to determine the presence of the medical symptom. The resident's subjective symptoms may not be used as the sole basis for using a restraint. Before a resident is restrained, the facility must determine the presence of a specific medical symptom that would require the use of restraints, and how the use of restraints would treat the medical symptom, protect the resident's safety, and assist the resident in attaining or maintaining his or her highest practicable level of physical and psychosocial well-being.

Medical symptoms that warrant the use of restraints must be documented in the resident's medical record, ongoing assessments, and care plans. While there must be a physician's order reflecting the presence of a medical symptom, CMS will hold the facility ultimately accountable for the appropriateness of that determination. The physician's order alone is not sufficient to warrant the use of the restraint. It is further expected, for those residents whose care plans indicate the need for restraints, that the facility engage in a systematic and gradual process toward reducing restraints (e.g., gradually increasing the time for ambulation and muscle strengthening activities). This systematic process would also apply to recently admitted residents for whom restraints were used in the previous

setting.

Consideration of Treatment Plan

In order for the resident to be fully informed, the facility must explain, in the context of the individual resident's condition and circumstances, the potential risks and benefits of all options under consideration including using a restraint, not using a restraint, and alternatives to restraint use. Whenever restraint use is considered, the facility must explain to the resident how the use of restraints would treat the resident's medical symptoms and assist the resident in attaining or maintaining his/her highest practicable level of physical or psychological well-being. In addition, the facility must also explain the potential negative outcomes of restraint use which include, but are not limited to, declines in the resident's physical functioning (e.g., ability to ambulate) and muscle condition, contractures, increased incidence of infections and development of pressure sores/ulcers, delirium, agitation, and incontinence. Moreover, restraint use may constitute an accident hazard. Restraints have been found in some cases to increase the incidence of falls or head trauma due to falls and other accidents (e.g., strangulation, entrapment). Finally, residents who are restrained may face a loss of autonomy, dignity and self respect, and may show symptoms of withdrawal, depression, or reduced social contact. In effect, restraint use can reduce independence, functional capacity, and quality of life. Alternatives to restraint use should be considered and discussed with the resident. Alternatives to restraint use might include modifying the resident's environment and/or routine.

In the case of a resident who is incapable of making a decision, the legal surrogate or representative may exercise this right based on the same information that would have been provided to the resident. (See §483.10(a)(3) and (4).) However, the legal surrogate or representative cannot give permission to use restraints for the sake of discipline or staff convenience or when the restraint is not necessary to treat the resident's medical symptoms. That is, the facility may not use restraints in violation of the regulation solely based on a legal surrogate or representative's request or approval.

Assessment and Care Planning for Restraint Use

There are instances where, after assessment and care planning, a least restrictive restraint may be deemed appropriate for an individual resident to attain or maintain his or her highest practicable physical and psychosocial well-being. This does not alter the facility's responsibility to assess and care plan restraint use on an ongoing basis.

Before using a device for mobility or transfer, assessment should include a review of the resident's:

• Bed mobility (e.g., would the use of a device assist the resident to turn from side to side? Is the resident totally immobile and unable to change position without assistance?); and

• Ability to transfer between positions, to and from bed or chair, to stand and toilet

(e.g., does the raised side rail add risk to the resident's ability to transfer?).
The facility must design its interventions not only to minimize or eliminate the medical symptom, but also to identify and address any underlying problems causing the medical symptom.
• Interventions that the facility might incorporate in care planning include:
o Providing restorative care to enhance abilities to stand, transfer, and walk safely;
o Providing a device such as a trapeze to increase a resident's mobility in bed;
o Placing the bed lower to the floor and surrounding the bed with a soft mat;
o Equipping the resident with a device that monitors his/her attempts to arise;
o Providing frequent monitoring by staff with periodic assisted toileting for residents who attempt to arise to use the bathroom;
o Furnishing visual and verbal reminders to use the call bell for residents who are able to comprehend this information and are able to use the call bell device; and/or
o Providing exercise and therapeutic interventions, based on individual assessment and care planning, that may assist the resident in achieving proper body position, balance and alignment, without the potential negative effects associated with restraint use.

Procedures: §483.13(a)

Determine if the facility follows a systematic process of evaluation and care planning prior to using restraints. Since continued restraint use is associated with a potential for a decline in functioning if the risk is not addressed, determine if the interdisciplinary team addressed the risk of decline at the time restraint use was initiated and that the care plan reflected measures to minimize a decline. Also determine if the plan of care was consistently implemented. Determine whether the decline can be attributed to a disease progression or inappropriate use of restraints.
For sampled residents observed as physically restrained during the survey or whose clinical records show the use of physical restraints within 30 days of the survey, determine whether the facility used the restraint for convenience or discipline, or a therapeutic intervention for specific periods to attain and maintain the resident's highest practicable physical, mental, or psychosocial well-being.

Probes: §483.13(a)

This systematic approach should answer these questions:
1. What are the medical symptoms that led to the consideration of the use of restraints?
2. Are these symptoms caused by failure to:
a. Meet individual needs in accordance with the resident assessments

including, but not limited to, section III of the MDS, Customary Daily Routines (MDS Version 2.0, section AC), in the context of relevant information in sections I and II of the MDS (MDS Version 2.0, sections AA and AB)? *{MDS 2.0 applies prior to 2010}.*
b. Use rehabilitative/restorative care?
c. Provide meaningful activities?
d. Manipulate the resident's environment, including seating?
3. Can the cause(s) of the medical symptoms be eliminated or reduced?
4. If the cause(s) cannot be eliminated or reduced, then has the facility attempted to use alternatives in order to avoid a decline in physical functioning associated with restraint use? (See Physical Restraints Resident Assessment Protocol (RAP), paragraph I). *{This applies up until 2010, when the MDS section for RAPs was altered by the government}.*
5. If alternatives have been tried and deemed unsuccessful, does the facility use the least restrictive restraint for the least amount of time? Does the facility monitor and adjust care to reduce the potential for negative outcomes while continually trying to find and use less restrictive alternatives?
6. Did the resident or legal surrogate make an informed choice about the use of restraints? Were risks, benefits, and alternatives explained?
7. Does the facility use the Physical Restraints RAP to evaluate the appropriateness of restraint use? *{This applies up until 2010}.*
8. Has the facility re-evaluated the need for the restraint, made efforts to eliminate its use and maintained residents' strength and mobility?

The following is a simplified version of the standards of care for nurses in either hospitals or nursing homes pertaining to fall prevention in those deemed at risk:

1. Patients are to be assessed for fall risk on admission, at the MDS review dates {for nursing homes}, upon transfer from one unit or venue to another, or upon any change in status.
2. A means for identifying that the patient is a fall risk such as a fall sticker, on ID band, door label, chart to assist others in awareness is a common practice.
3. Reasonable prevention interventions specifically tailored to that patient {and not a canned list} is required to be in a care plan. Nearly all such facilities have policies and procedures on this area developed to guide nursing staff. Examples of such interventions may include: low bed, padded side rails, bolsters for bed {prevent rolling out of bed}, bed/chair alarms {many types}, move patient in close view of staff, self-releasing Velcro seat belts, providing some things to do or activity for the patient specifically. Some residents enjoy folding towels, or folding paper into envelopes. Paying attention to such things may negate equipment needs. There are many more methods that a facility may employ. Their own policy will state this and that is their standard of care. No regulation

will list any intervention. The regulation states that the facility must assess on a continuous basis, the indication for and appropriateness for any intervention that is determined.

4. Reassessment is the key. This is where many organizations miss a step. They do the admission fall risk assessment, but fail to revisit, resulting in a fall and possible injury to the patient.
5. Common areas of focus for fall risk are: toileting of patients on a regular basis, monitoring of and knowing the effects of the following class of medications: narcotics, other pain medications, antihypertensive agents, hypnotics, benzodiazapines. Although falls can occur at any age, it is more common to see those who are elderly, and/or cognitively impaired falling more often. Such patients try to go to the bathroom by themselves, or can't remember to ask for help, or can't use a call bell. Medications may be more pronounced in such patients as well, and cause confusion and unsteady gait.
6. Use of restraints are to be judicious. Proper assessment and consent for are required as well as the choice of least-restrictive in a step-wise fashion. Restraint use is to be reassessed on a regular basis {usually monthly in nursing homes, and certainly more often in hospitals-usually on a daily basis.} Care plans for use of restraints of any type are to be present in the record.

Your Legal Nurse Consultant can guide you in this area. Choose such a consultant/expert who has real tangible experience in both hospitals and nursing homes, or home care for the most reliable testimony.