Fall Prevention in Skilled Nursing Facilities: A Multidisciplinary Proactive Team Approach to Avoid Negative Health Outcomes and Legal Pitfalls

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Post-Acute and Long Term Services Practice Group

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Fall prevention for residents in a Skilled Nursing Facility (SNF) has become one of the paramount quality indicators for best practice care. When facilities fail to properly initiate and adapt an individualized plan of care for fall prevention, it leads to negative health outcomes for the resident and places the facility at legal risk. SNF falls frequently cause debilitating injuries requiring emergent treatment at acute care hospitals. This results in disability, decreased quality of life, and increased health care costs.

**SNF Fall Statistics:**

- In 2003, the Centers for Disease Control and Prevention (CDC) estimated 1.5 million adults over the age of 65 were living in a SNF. At this rate, there will be roughly 3 million SNF residents by 2030.
- Between 16% and 27% of SNF falls occur due to environmental hazards, such as inadequate lighting or slippery floors.
- Between 50% and 70% of elder residents suffer from a fall each year. This rate is twice as large as the rate of falls that occur for elders living independently.
- The CDC estimates that roughly 5% of elders, age 65 and over, are SNF residents. However, SNF residents make up 20% of deaths as the result of a fall.
- SNF residents typically fall multiple times each year. The CDC averages this statistic at 2.6 falls per SNF resident, per year.
- Roughly 35% of elderly fall injuries happen to SNF residents who cannot walk.
- Between 10% and 20% of nursing home falls result in serious injury.
- Between 2% and 6% of SNF falls result in fractures.
- Approximately 1,800 residents die each year as a result of SNF falls.¹

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• The average cost for a fall with injury is about $14,000.²

Recent SNF Lawsuit Settlements Involving Falls:

• $620,000 settlement against a SNF for a fall.

• $450,000 settlement against a SNF for a fall resulting in hip fracture and sacral pressure ulcer.

• $375,000 settlement against a SNF for a man who suffered a fall that resulted in a subdural hematoma and surgery.

• $350,000 settlement against a SNF who suffered a fall from her chair resulting in a subdural hematoma.

• $365,000 settlement for a woman who suffered multiple falls, fractured hip, subdural hematoma and death.

• $250,000 settlement for a woman who suffered a fall which resulted in a subdural hematoma and death.

• $300,000 settlement for a woman who sustained a fall that resulted in a fractured humerus.

• $250,000 settlement against a SNF for a woman who suffered a fall that resulted in a fractured hip.

• $205,000 settlement against a nursing home for a fall resulting in a fractured tibia and fibula.³


Guidelines for Practice:

All SNFs are under federal regulations governing long term care as directed by the Centers for Medicare & Medicaid Services (CMS). These regulations are commonly referred to as F-Tags. Fall Prevention is covered by F-Tag 323 which states, in part:

F323

The facility must ensure that:

(1) The resident environment remains as free from accident hazards as is possible; and

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

Intent: 42 CFR 483.25(d) (1) and (2) Accidents and Supervision

The intent of this requirement is to ensure the facility provides an environment that is free from accident hazards over which the facility has control and provides supervision and assistive devices to each resident to prevent avoidable accidents. This includes:

- Identifying hazard(s) and risk(s);
- Evaluating and analyzing hazard(s) and risk(s);
- Implementing interventions to reduce hazard(s) and risk(s); and
- Monitoring for effectiveness and modifying interventions when necessary.  

These regulations are enforced by CMS through the respective state’s Department of Health’s Survey Process.

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Proactive Fall Prevention:

Fall prevention starts on day one of admission. Clinicians will review the medical abstract for any conditions that would place the resident at risk for falls. These include, but are not limited to:

- Previous fall history
- Use of psychotropic medications (i.e. antidepressants, anxiolytics, antipsychotics)
- Incontinence issues
- General decline of functional status
- Poor vision
- Use of cardiac medications (i.e. antihypertensives, diuretics, etc.)
- Additionally, polypharmacy, or the use of multiple medications is highly associated with increased rates of falling. Ten to twenty percent of falls can be related to medications.\(^5\) As indicated by Steinweg, drugs such as sedatives, anxiolytics, antidepressants, and antihypertensives may directly lead to falls related to postural hypotension, sedation, decreased reaction time, or decreased cognitive abilities. The use of psychotropic medications doubles the risk of recurrent falls, even after controlling for dementia, depression, and other risk factors.\(^6\) In one study, tapering and eventually stopping use of psychotropic medications was associated with a 39% reduction in the rate of falling.\(^7\)

- Impaired cognitive status (i.e. dementia, delirium, Alzheimer's, etc.)
- Use of adaptive equipment (i.e. wheelchair, walker, etc.)

\(^6\) Sjogren, *infra* note 5.
\(^7\) Id. (citing ME Tinetti, *Preventing Falls In Elderly Persons*, 348 THE NEW ENGLAND JOURNAL OF MEDICINE 42-9 (2003)).
• Recent orthopeadic injuries
• Pain
• Change of customary routine/environment
• Infectious processes that may contribute to the development of delirium
• Non-compliance with health care directives

The Following Steps Should Be Taken to Avoid Falls

1. **Admission:**

   • Utilize a clinically acceptable Fall Risk Assessment Tool. This is a form, that when completed, gives the clinician a numerical score for fall risk.

   • Initiate fall prevention interventions immediately. Fall prevention interventions include, but are not limited to:

     o Proper fitting non-skid footwear
     o Adequate Lighting
     o Call bell in reach at all times
     o Adequate supervision by staff
     o Adequate level of assistance for activities of daily living
     o Initiation of a three-day bowel and bladder tracker for incontinency/toileting patterns
     o Review of Medications
     o Utilization of adaptive equipment
     o Fall prevention alarms
o Floor mats

o Bed sensors

o Specialty Mattresses

o Hip protectors

o Diversional activities for cognitively impaired residents

2. Multidisciplinary Team Approach:

Each discipline located within a SNF is challenged to promote the highest level of care possible. Listed below are what disciplines are present and respectively how they can achieve the goal of positive outcomes.

A. Nursing

- Nursing comprises the largest discipline in a SNF. They are the “eyes and ears” of the health care team. Fall prevention starts here. All clinical aspects must be constantly assessed and evaluated for effectiveness of individualized fall prevention. Avoid “cookie cutter” approaches to fall prevention. For instance, if the resident has a history of getting up in the middle of the night to go to the bathroom, institute a toileting plan to address those needs. If the resident requires two persons for assistance with transfers, ensure that respective level of care occurs 100% of the time. Failure to provide the required level of assistance can lead to a neglect issue.

- Pain: Every person exhibits/tolerates pain at different levels. If a resident is experiencing pain, they may attempt to change to a position of comfort. This can create risks for falls, especially in the cognitively impaired
resident. Pain should be assessed at least every shift for effective management/control.

- Toileting: Toileting needs are paramount to decreasing the risk of falls. Evaluate, assess and implement a personalized toileting program to meet that respective resident’s needs. Review the implemented plan monthly and make adjustments to toileting schedules as warranted.

B. Therapy

- Residents, in most if not all cases, require skilled therapies. Physical Therapy (PT) will determine the required level of assistance that each resident needs. This is then conveyed to nursing to ensure continuity of care needs. Therapy will assist the resident to achieve the highest level of functioning through various modalities utilized according to the individualized plan of care. Professional therapists can assist in pain management as well utilizing different therapeutic modalities.

C. Activities Department

- The activities department plays a vital role in health care wellness. Activities should be resident specific according to their respective customary routines. For cognitively impaired residents, activities should be structured in a way to provide behavioral/diversional management, cognitive stimulation, etc. Overstimulation can increase the risk of falls in cognitively impaired residents. These identified residents should have personalized interventions incorporated into their plan of care to reduce said risk.
D. Pharmacy

- Pharmacological agents can increase the risk of falls in elderly residents. Consultant Pharmacists should be utilized for medication reviews of all residents upon admission, quarterly, and with any significant change in health status (i.e. recent fall). These recommendations are then reviewed with the primary care physician for efficacy/implementation.

E. Maintenance Department

- Maintenance is responsible for a safe environment for all residents. They must ensure resident areas are free from hazards (i.e. clutter, inadequate lighting, slippery floors, etc.). Maintenance should be reviewing environmental concerns on a daily basis and providing remedy to the same.

Time to Change Course?

Fall prevention interventions must be constantly fluid. If a resident experiences a change in condition (i.e. change in vital signs, new diagnosis, recent fall, change in mentation, significant change in health status, etc.), the multidisciplinary care team must re-evaluate and institute fall prevention interventions immediately. Not all interventions will be/remain effective. The team needs to determine what interventions are not effective and adjust accordingly, perform root cause analysis for all incidents, update the resident’s plan of care, utilize the Quality Assurance/Performance Improvement Team to perform risk management on all incidents and how to prevent reoccurrence, and incorporate all changes/suggestions into the resident’s daily customary routine.
Conclusion

Falls are the leading cause of debilitation, negative health outcomes (i.e. injury, increased length of stay, death), and litigation for SNFs. A well-managed, fluid, proactive health care team that is resident/positive outcome focused can provide the highest quality of care for residents, decrease number and severity of falls, and limit costly litigation through constant fall prevention management. All of the aforementioned items are required to prevent successful litigation in the event of a fall with injury. To determine if there was any deviation from the standards of care, an attorney should study F323 and review the items listed above in order to successfully litigate/defend their cases.