



## Falls: Evaluation of Liability

If you are a legal nurse consultant getting cases, chances are you have or will review a fall case. Falls can occur in homes, workplaces, outside, and in healthcare facilities – anywhere people walk, right?

This is Pat Iyer with Iyer's insights, one of the twice weekly shows of Legal Nurse Podcast.

In this podcast I focus on healthcare falls. Injurious healthcare falls are one of the most common reasons why providers are sued. Spinal cord injuries, head injuries, and fractures make these serious cases for attorneys and nursing expert witnesses.

There are so many factors that could cause a fall, but from a liability perspective, the issue that is of highest concern for attorneys, risk managers, expert witnesses and insurance carriers is **which of those healthcare falls could have been prevented.**

Many states have regulations that govern who is qualified to act as a liability expert. LNCs who excel as experts have

- a combination of recent or current clinical practice that matches the clinical setting where the fall occurred,
- excellent communication skills,
- and finely-honed analytical abilities.

What I am sharing in this podcast can be a great checklist to follow in analyzing a fall case. You can get the transcript of this show by subscribing to our transcript option on [podcast.legalnursebusiness.com](http://podcast.legalnursebusiness.com).

Of course, you might be screening a case for merit and not acting as an expert. Whether you are behind the scenes or an expert witness, consider these questions for a healthcare fall analysis:

- Which healthcare falls should have been prevented by the actions of either the healthcare providers or the people who designed the environment in which the fall

occurred?

- Was the patient identified as being at risk for falls?
  - How was that risk communicated to others?
  - Were measures implemented to prevent the fall?
  - Did the patient call for assistance before getting up?
  - Was the patient capable of using the call bell?
  - Was the bed in its lowest position?
  - Were lights on in the room or under the bed to help light the area at night?
  - Was the patient given anti-skid slippers?
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- Is it possible to determine how soon the individual was found after he had sustained the fall?
  - What was done at the time of the fall?
  - Was the patient appropriately monitored after the fall to detect injuries?
  - What did the assessment reveal?
  - Did the nurse communicate the findings to the physician?
  - Were X-rays ordered and performed?
  - Was there an injury and how soon was that injury treated?
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- If the patient fell and hit his head, was the chart reviewed; was the individual on anti-coagulation blood thinner such as Heparin or Coumadin?
  - Was this communicated to the physician so that head scans could be performed to see if there was some type of bleed in the head?
  - Was there a change in mental status after the healthcare fall?
  - What were the vital signs?
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- Were there specific conditions which contributed to the fall?
  - What medications had the patient received prior to the fall? Did they have side effects that could have contributed to the fall?
  - Was the patient's risk for falls identified after the fall and the plan of care changed? Was the new plan implemented to minimize the opportunity for other falls to occur?

Here are some of the common deviations plaintiff's expert witnesses identify. The environment may have contributed to the fall by posing a challenge for a patient with a visual problem. A patient of any age may have difficulty seeing, but the issues are more common in the elderly. Nurses are expected to recognize the visual

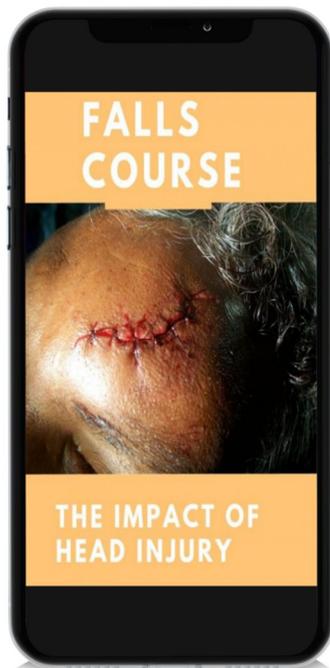
changes associated with aging and provide individualized measures to help prevent a fall.

Look at the medical record to see if any of these measures were followed:

- use nightlights in the bathroom and bedroom
- avoid a cluttered environment
- provide large print room door tags with the patient's name and room number
- keep clothes and objects in the patient's room in the same positions
- place fluorescent or brightly colored tape around outlets, light switches, and doorknobs
- mark eyeglasses with the patient's name
- keep commonly used objects within reach of the patient so searching and stretching to reach something will not be needed

There are many factors associated with analyzing liability for a healthcare fall. Many things can go wrong to create the conditions that lead to a fall.

Do you want to hear some stories? Let me tell you about some examples of deviations alleged in actual fall-related cases that *I* saw in cases that we handled at my LNC business.



Before we continue with the show, I'll share a resource you'll find helpful in evaluating fall cases. I am referring to my course called "Falls Course: The Impact of Head Injury".

I invited nursing experts to participate with me in this course so you would get the tools you needed to analyze a falls case, and with a focus on head trauma.

### **What can this course do for you?**

**1. Gain insight and practical tools about how to analyze a head trauma case.** You will gain skill in reviewing facts of a fall case and learn from expert witnesses who have reviewed hundreds of

cases.

**2. You'll learn skills and techniques you can use immediately.** The course is not full of dry theory; it is a fast paced, comprehensive way to learn practical, useful information.

**3. Review the course over and over.** Not only will you be filled with useful information at the end of each session, when you purchase the course, you'll be able to re-watch the replay and review the transcripts.

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The first category of stories I will share related to the failure to follow standards of care. I know, that is a broad category. Here are examples.

- failure to follow the care plan intervention that two people were needed to transfer a patient
- failure to support a paraplegic patient during a shower caused a fall and fractured pelvis
- failure to respond to a patient's call for help resulted in the patient getting up on her own and falling
- failure to appropriately train staff in transfer techniques resulted in a head injury when the patient was being transferred out of bed
- failure to respond to a patient's request for help to get off a commode

**Here is another category: Failure to use equipment in a responsible manner. This included**

- failure to use bed alarms and sensors
- failure to ensure that batteries were working in sensors
- failure to properly maintain a Hoyer lift, resulting in a fall
- failure to use a low bed close to the floor
- failure to put up a side rail before rolling a patient on her side led to a fall off the bed (gravity takes over)
- failure to lock the wheels of a bed or wheelchair
- failure to ensure that doors to the outside or stairwells were not left propped open on nursing units with cognitively impaired patients

**This is another category: Failure to communicate**

- failure of the nurse to fill out forms instructing the aides on how to follow fall precautions for a woman with a previous history of a fractured hip
- failure to report a fall, leading to a delay in diagnosis of fractures
- failure of the nurse to instruct caregivers on proper transfer techniques

## **I bet you knew this one was coming: Failure to document**

- failure to establish and record a plan to prevent falls in a patient with 57 falls and 18 head injuries
- failure to report and record details of a fall
- failure to record telephone orders for fall prevention measures

## **There's more: Failure to assess and monitor**

- failure to monitor a patient who fell repeatedly, ultimately resulted in loss of an eye during a fall in a parking lot
- failure to assess and monitor a patient following a head injury led to undetected increases in intracranial pressure and death

## **Here's the last one: Failure to act as a patient advocate**

- failure to report signs of lethargy consistent with over-sedation, followed by a fall
- failure to question excessive doses of psychotropic medications
- failure to obtain a medical examination after a fall

We know healthcare providers are expected to act as patient advocates to secure help for their patients. Think about how a delay in treatment can occur. This could be because:

- The healthcare providers *did not collect* the appropriate data needed to assess the patient's condition. The person who fell was not thoroughly assessed and an injury was missed.
- The appropriate data was collected but the healthcare provider *did not have the knowledge to critically analyze* the data to find its meaning. The signs of a fracture were overlooked.
- The data were collected and analyzed, but the appropriate healthcare provider *failed to respond* to another person's concerns. The nurse could not get the attention of the physician or the nurse's concerns were dismissed.

- The concerns of the bedside clinician were heard, but the provider *did not or could not make timely decisions* about what to do about the changes in the patient's condition.

As you can see, there are lots of variables that can influence the liability.

That is it for today. Be sure to invest in our **Falls Course** to sharpen your analysis of these kinds of cases. You'll see a button on the show notes for this podcast. Go to [podcast.legalnursebusiness.com](http://podcast.legalnursebusiness.com) and check the show notes.

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