Patient falls create liability issues for health care providers

By Chris Rokosh

Patient safety has moved to the forefront of the health care agenda. Patients who enter into an acute care hospital are often vulnerable because of their illnesses and disabilities and the provision of safe care becomes not only a fundamental patient right, but a moral and ethical imperative to all members of the health care team.

In Canada, the top two reported patient safety issues are related to medication errors and falls and/or injuries related to patient restraints. Most of the reported medication errors are dose related and do not have significantly adverse outcomes. On the other hand, falls result in injuries which range from minor injury to death 20 to 30 per cent of the time; making them a significant focus of prevention, reporting and risk management strategies.

This article will examine an actual fall in an acute care hospital, factors contributing to a fall and recommended documentation of prevention and treatment strategies.

The patient, a 74 year old male was admitted to hospital for a left knee replacement due to pain and limited mobility caused by osteoarthritis. Past health history was significant for high blood pressure for which he took medication, limited vision and arthritic pain in his right knee and hip. The surgical procedure was uneventful. Postoperatively, he was prescribed intravenous narcotics and blood thinners to control the pain and prevent a deep vein thrombosis.

For the first 48 hours after surgery, he remained mostly in bed with the side rails up, was significantly confused from the effects of anesthesia and narcotics and instructed not to bear any weight. By the third postoperative day, his pain had improved, narcotics were discontinued, one side rail was put down and he was encouraged to be out of bed. He was prescribed Tylenol #3 for pain and was getting around relatively well with the use of a walker.

On the evening of the third day, he was given a sleeping pill. At 2:00 a.m., confused and disoriented, he attempted to walk to the bathroom without his walker. He fell, fracturing his left wrist and hip and suffered significant internal bleeding and bruising. He required two further surgeries, multiple blood transfusions and 27 days additional hospitalization.

This fall may have been prevented by identifying risk factors and then putting the bed rails up. The most commonly identified risk factors for falling seem to have been written just for this patient. They include; advanced age, altered mental status, history

Chris Rokosh

of falls, medications, toileting needs and impaired mobility. Most falls in hospital are reported to occur at the patient bedside and the most common activity at the time of the fall is getting out of bed.

Review of the medical documentation related to this patient's fall, which resulted in litigation, begins with a look at the hospital fall prevention policies which should include;

1. A "Fall Risk Assessment" with a schedule for reassessment (on admission to hospital and following any changes in patient status, such as surgery)

2. Documentation requirements for assessments, plan of care and interventions

3. Methods to communicate changes in the plan of care to all health care providers

A multidisciplinary approach to patient safety is essential and the following safety measures, proven effective for preventing falls, should be put into place and clearly documented by the hospital staff providing care:

- Side rails on the bed placed in the "up" position
- The patient call bell and bed controls placed within easy reach
- Clear communication to the patient to call for assistance before getting up
- Necessities such as water, eyeglasses, tissues, telephone and urinal placed at the bedside and within easy reach.
- The bed lowered to its lowest height
- The patient familiarized with their new environment
- The pathway to the bathroom free from obstacles and properly lit
- Clear communication among hospital personnel of the risk for falling and the safety measures in place

see DOCUMENTATION p. 13

Review hospital policies

DOCUMENTATION

–continued from p. 9–

Following the fall, documentation in the medical record should include;

- The patient's condition when they were found
- Direct quotes from the patient regarding their condition and the events surrounding the fall and the injury
- A thorough physical assessment and identification of injuries
- Safety initiatives taken to prevent further harm to the patient
- Physician notification, communication and examination
- Diagnostic studies undertaken and their results
- Family notification
- Evidence of ongoing monitoring of patient condition
- Other care and reporting requirements as dictated by hospital policy

Given the many intrinsic and extrinsic factors that can contribute to an injurious fall, medical/legal investigation should include a review of hospital policies followed by examination of the medical documentation for evidence of a fall risk assessment (and reassessment following a change in health status), development of a safe plan of care and implementation of appropriate safety interventions.

Chris Rokosh R.N. is the president and chief nursing consultant of Legal Nurse Consulting Services in Calgary, Alberta; providing expert nurse witness services to plaintiff and defense lawyers across Canada.