

Report From the Trenches: Defending Patient Falls in Acute Care Settings

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Patients (and jurors) often have preconceived notions that a fall should never occur during a hospitalization.

Hospitals themselves may have inadvertently created this higher expectation by adopting preventative measures for patients who are at higher risk for falls. This may make it harder to secure a favorable verdict in hospital fall cases. The following are practical lessons learned from defending these common lawsuits.

DOCUMENTATION PRODUCTION

As most health care claims professionals know, documentation is the backbone of litigation. Cases can be won or lost based on the medical chart. It is engrained in our minds to only provide the medical record during discovery. This is largely because (theoretically at least) all of the relevant medical information pertaining to the fall should be contained in the clinical record. However, and particularly with falls, specific information pertaining to a fall may be recorded in a number of other lesser known places, such as nursing administrative reports, post-fall clinical evaluation forms, risk management incident reports, and other documents.

In cases where the clinical record is poor, incomplete or perhaps incorrect, it is advisable to think outside the box and produce these extraneous documents.

Oftentimes, they provide more details on the fall and interventions than what is in the chart. Conversely, the absence of additional records after a purported unobserved fall can assist in the argument that a fall, in fact, did not occur. A word of caution, however -- just as these extraneous records can assist in defending a case, they can also be detrimental in another. Once the "genie is out of the bottle" it may be hard to argue against the production of extraneous records in subsequent cases.

PICTURES AND VIDEOS

With fall cases, there are other types of evidence that need to be examined. Defense counsel should perform a site inspection of the fall area as soon as a claim is made and preserve with photographic evidence how an area appeared when the fall took place. A site inspection can show how many call bell strings were near a patient before they fell, or show the existence of placards or written warnings to the patient to seek assistance before a transfer. It additionally can show the fall risk warnings on the doors for the nurses to see before they enter the room. If a site inspection does not take place, you could be missing an opportunity to strengthen your defense.

Defense counsel should also check to see if a security camera captured the fall. Video surveillance data usually self-erases after a period of time, so it is a race against time to

locate and preserve a video recording of a fall if captured by a security camera. Moreover, legal opponents may make an issue of spoliation or “cover up” if the fall area could be captured by video and no attempts were made to preserve the evidence. Written evidence of the request for video surveillance preservation should be maintained for possible production in discovery to demonstrate that the request was per the usual protocol.

KNOW FALL RISK SCORING AND ITS LIMITATIONS

Plaintiff’s negligence theory regarding patient falls is fairly straightforward: 1) identify the hospital’s patient fall risk protocol; 2) compare it to the care rendered and risk protocols used on the patient, and then 3) either challenge the scoring as inaccurate (i.e., the patient was actually a higher risk for falls) or assert that the nurses were not in compliance with the fall risk protocol. In other words, use the fall risk protocols to establish the nurses’ duty and scrutinize the care. Therefore, defense counsel needs to familiarize themselves with the institution’s fall risk protocols, the nuances of risk scoring and the unreliability of documented fall risk scoring.

The first thing that defense counsel must impress on a jury is that fall risk scoring has existed for several years, yet despite its introduction and use, the statistical retrospective analysis indicates simply that it does not reduce hospital falls. That is a powerful foundation, but the skeptical counter to this statement is, “if these protocols don’t work, why do hospitals still use them?” The response is that while the retrospective statistical analysis demonstrates that fall risk scoring has not reduced falls, being more aware of a patient’s condition and implementing safeguards is

simply the right thing to do. If the use of the fall risk scoring prevents just one fall, it is worth it.

Another point of emphasis in explaining fall risk assessments to a jury is that they are not accurate predictors as to whether the patient will suffer a fall. The vast majority of high risk for fall patients do not, in fact, suffer a hospital fall. Another example is when a low risk patient falls. The scoring is not predictive of falls, rather it highlights the risk factors for falls.

With fall risk scoring, two patients may score identically, but if you look further into their histories, it is clear they are not at the same risk for falls. For example, an 85-year-old dementia patient with a secondary diagnosis of diabetes who reported a prior fall at home due to dizziness and is on an IV can score identically to a 34-year-old diabetic who is on an IV who reported a fall at home when he tripped on a rake while doing yard work. While they will score the same on a fall risk assessment, it is clear that the elderly patient is at higher risk for falling when you consider the medical history.

The timing of the fall risk assessment is also important to explain to a jury. They are usually recorded once per shift in a hospital setting and represent the risk for fall at the time of the assessment. However, the fall risk assessment can change over a shift. The best example is with elderly “twilighters” who get more confused as the day progresses. On a 3pm to 11pm shift, a “twilighter” may score as a low risk for a fall at 4pm, but by 9pm, the risk clearly increases. The hospital documentation will typically not allow, nor will the nurses typically document, a supplemental fall risk assessment as the shift progresses. So when retrospectively evaluating a fall risk score, the exact time

that the score was documented during a shift is important in evaluating the care. It may be inaccurate based on its timing in relation to other patient care factors.

When it comes to falls, comparing a hospital fall to a fall in a long term care facility is like comparing an apple to an orange. Although they seem the same, there are differences between the two that a jury should know about. First, hospitals care for acutely ill patients, whose conditions can change dramatically over a short period of time. Contrast that to long term care patients, who tend to have more stable courses of care which lends to more predictability. Because of this, there can be less certainty and more variability in explaining the fall risk of a patient in a hospital setting compared to a long term care facility. Further, hospital patients tend to have more documented interventions by a number of specialists from a larger personnel pool. Each specialist who evaluates a patient can have their own subjective thresholds in determining a patient's fall risk. In long term care facilities, there are less interventions by a smaller group of specialists who will know a patient better. Lastly, because senior living patients are treated over a longer time period, the care providers can be more familiar with their residents, especially when it comes to their physical limitations. If a patient's lawyer attempts to criticize a hospital for not having the same success or fall intervention protocols as a nursing home, these nuances need to be highlighted.

MAKE YOUR CLIENTS EXPERTS ON FALL PREVENTION STRATEGIES

Unless a patient's lawyer previously worked as a health professional, few realize that medicine is an art and not a "black and white" profession. Typically, the patient's lawyers will request copies of an institution's

policies and procedures, compare it to the care, and when the care is not consistent with the policy, negligence is claimed. When preparing policies and procedures, hospitals should incorporate language that includes the terms "discretion" or "judgment" when possible. It makes it easier to defend any type of case in the future because the term "nursing discretion" is recognized as a part of a safety protocol.

In defending a fall case, witnesses should be prepared on how to address any alleged discrepancies in following a policy. The policy from the time at issue should be shared with the witness before the deposition, and together, the attorney and witness should compare what they did to what should have been done. Although it may appear at first blush that care was not consistent with the policy, take the time to learn of the health care client's typical practice and know how the patient was faring in the nursing shifts immediately before and after the care to get a full picture of their condition. It can reasonably explain why the nurse acted in a certain manner.

Those in hospital administration and risk management know how important fall prevention is to the institution. Their counsel should take the time to explain to the jury everything that is being done—from patient education upon admission, to how patients are continuously evaluated for falls and reminded not to do anything that puts them at further risk. The jury should also be educated on posted warnings, which provide constant visual reminders to patients and nursing staff on the importance of safe transfers. If a jury hears the totality of fall risk reduction strategies, it will cut into the patient's argument that a fall was due to neglect or because the patient was ignorant on the issues. Culminating the education

process, it should be shared with a jury that despite everything being done to prevent falls (including 1:1 care, the use of bed alarms, and continuous education) patients still fall. If verifiable fall data from your institution exists that shows this, use it. A jury will understand and forgive if you show it everything that is being done to prevent falls.

Lastly, in explaining how a patient fell, do not forget to explain to a jury the importance of patient decency. For example, a policy for high-risk patients may indicate the need to “stay with patient” during toileting. However, a nurse using her clinical judgment, may feel that it is appropriate to pull a curtain or partially close a door, to let the patient have privacy during a vulnerable moment. In situations where a fall occurs when a patient was not observed during toileting or some other event that could impact decency, do not forget to stress the importance of human dignity. Patients do not check privacy at the door during a hospitalization. It has been my experience that juries appreciate this explanation because it shows the totality of evaluations that occur with each individual patient.

THE LAST WORD

Hospital staff face the most scrutiny during fall cases. Obviously, their care and decision-making is at issue and they need to be able to answer tough and pointed questions. The hard questioning, however, should not be limited to the health care providers. As a way to explain the care to a jury, defense counsel should question the plaintiff about what they knew or understood about the hospital’s fall risk protocols.

For example, it is common for hospital staff to orient a patient as to their room, call bell and need to be assisted with transfers. In some instances, it is done every shift. Confront the patient with the chart entries and have them confirm that it was done. It is a win-win scenario to have the plaintiff confirm that they were educated on the fall risks. First, it shows that they knew they were at risk for a fall and despite that knowledge, knowingly acted in a way that put them at a greater risk for falls. Second, by confirming the fall risk precautions, it gives greater witness credibility to your hospital staff. Third, if the plaintiff denies being educated on fall risk procedures despite what is documented, it makes them look less credible to the jury. By confirming hospital fall risk protocols with the plaintiff, it is an indirect argument that the plaintiff contributed to their unfortunate outcome. If it can be confirmed by the plaintiff that they acted in a way inconsistent or contrary to what they were told, it only helps the case.

Unfortunately, patient falls will happen no matter the intervention. By educating the jury, witnesses and the court on all of the things hospitals are doing to protect their patients from falls, it will only increase the chance for a favorable outcome when and if a lawsuit is filed.



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