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Falls: *Avoidable* versus *Unavoidable*
Part II
Risk: *Probable, Possible, Unpredictable?*

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Surveyors *ARE* Citing F314...

Part II of this mini-series will look at risk assessment in the context of a surveyor's subsequent determination of whether the resident's fall was avoidable or *un-avoidable*.

As was included in the mini-series overview, it is clear from the language in F323's Investigative Protocol that the determination of compliance with F323 hinges on the surveyor's determination of 'avoidable/unavoidable' when evaluating resident accidents.

An essential aspect of that decision-making involves review of the fall risk assessment process.

Per the Guidance:

- ⊕ "Accident" refers to any unexpected or unintentional incident, which may result in injury or illness to a resident.
- ⊕ "Risk" refers to any external factor or characteristic of an individual resident that influences the likelihood of an accident.

Please note the underlined portions of the above definitions. For an accident/fall to be truly unexpected (and therefore *un-avoidable*), the facility's risk assessment process needs to fully explore the probable, the possible and unpredictable!

Oh come on! How can a facility be expected to assess the unpredictable?? Isn't 'unpredictable' the same as 'unexpected'? Some times you don't need a crystal ball to predict the unpredictable – you do need to include the right questions in your risk assessment.

Most fall risk assessment tools cover the areas of cognitive status, history of falls, continence, gait/balance, ambulation/devices, etc., by asking very general questions and requiring check marks or assignment of a numerical score. Example: Cognitive impairment = Yes; Gait/balance problem = Yes; History of falls = Yes; Ambulation Device = Yes.

While this information does tell us that the resident is at risk for falls, it doesn't do much more than that – and it certainly doesn't help us to predict the unpredictable. Consider adding the following types of questions to your existing fall risk assessment tool:

Examples:

Cognitive/Mental Status:

- ⊕ Cognitively Intact but unwilling to accept physical limitations.
- ⊕ Cognitively Intact but behavior/mood places resident as risk (fear, anxiety, anger)
- ⊕ Cognitively Impaired; currently does not attempt action beyond physical capabilities.
- ⊕ Cognitively Impaired; routinely attempts action beyond physical capabilities.
- ⊕ Poor safety awareness; does not recognize potential hazards in the environment, i.e. wet floor, obstacles in path.

History of Falls:

- ⊕ Most recent falls associated with _____.
- ⊕ Trend/pattern re time of day _____.

Ambulation/Devices:

- ⊕ In room, substitutes furniture for assistive device.
- ⊕ Does not consistently wait for assistance.
- ⊕ Proximity of device will prompt resident to attempt unassisted ambulation/transfer

Gait/Balance:

- ⊕ Once leaning, unable to resume erect seating posture.
- ⊕ Cannot correct for slight loss of balance.
- ⊕ More difficulty on, i.e. carpeted vs smooth flooring.
- ⊕ More difficulty with type of footwear.

The above questions will:

- ⊕ Yield more specific information about the resident thereby increasing the facility's ability to 'predict' risk and develop meaningful fall prevention interventions.
- ⊕ More accurately assess the types and degree of 'unpredictable' resident behavior/actions.
Example: The resident has demonstrated that they may, at times, attempt actions beyond their physical capabilities. We may not know when they will attempt such an action but we know at some point they will. We have therefore assessed that the resident will likely act in this predictable way at 'unpredictable times' – and can implement interventions in the event that...
- ⊕ Assist staff in coming to grips with the fact that, for some residents, the only thing that can be predicted is their *un*-predictableness. This recognition/acceptance can lead to more effective care plan intervention development from the 'what if' perspective rather than 'Oh gosh, what next?'

Scenarios:

The resident has resided at the facility for 2 years; is alert and cognitively intact; requires assist with transfer from bed; is aware of and accepts the fact that she requires assist with transfer as evidenced

by the fact that she ALWAYS uses the call light and waits for staff to respond; has had no falls related to transfer since admission.

- ⊕ Scenario A: Last night the resident did not use the call light, attempted self-transfer from bed and fell to the floor. The resident stated that she wanted to get her book from the dresser and didn't want to be a bother. She had no other explanation as to why on this singular and isolated occasion she did not use her call light. (Call light was accessible, staff were in the vicinity, resident was her usual self, etc)
 - Comments: When all factors were evaluated in this scenario, it appears that this resident's actions were truly unexpected and unpredictable. There wasn't anything that staff were or should have been aware of that could have led them to anticipate or entertain the possibility that the resident was going to act in an unexpected/unpredictable way. Therefore, it is reasonable to determine that this fall was *un-avoidable*.

- ⊕ Scenario B: For the past several days the above-described resident has had and is being treated for an upper respiratory infection. Her temperature is fluctuating, her food/fluid intake has been significantly decreased, she has been on bedrest and she has been noted to be somewhat confused to her surroundings upon waking. Last night the resident did not use the call light, attempted self-transfer from bed and fell to the floor. The resident stated that she thought it was time to get up and get dressed.
 - Comments: Although the resident had a long history of dependable call light usage and waiting for staff assistance to transfer, there were new issues in play, i.e. acute illness, weakness, confusion upon waking – all factors that were known by staff. Based upon this knowledge, it could be/would be argued by a surveyor that the staff had sufficient information to anticipate/predict that the resident might/could/would act in an unpredictable way – and required additional, if temporary, interventions and/or supervision. As a result, this fall could be seen as avoidable.

When a facility can demonstrate that their ongoing risk assessment process is comprehensive enough to identify the probable, possible and unpredictable (and they consistently implement commensurate interventions), the documentary evidence exists to support a determination that the accident/fall was truly *un-expected*, *un-predictable* and *un-avoidable*. And the facility can predict compliance with F323.

Surveyors ARE Citing F314...

The F314 Guidance to Surveyors refers to the availability of statistically validated instruments to assess risk for developing pressure ulcers, i.e. the Braden Scale, the Norton, etc. These validated tools, by evaluating an individual resident against a set of risk categories, assist the facility in determining the individual resident's level of risk by the assignment of a numerical score. The numerical score is then correlated to a determination of low, moderate or high risk for pressure ulcer development.

Many facilities have experienced, as this column as previously discussed, that inter-assessor reliability and varying (sometimes incorrect) interpretation of the risk categories can significantly affect the individual resident's 'score' and subsequent identification as low, moderate or high risk. This may then adversely affect the prevention strategies implemented on the resident's behalf.

Another pitfall... surveyors have been referring to the skin risk assessment score in terms of 'failure to assess/accurately assess resident's risk.' When is this occurring? In cases when, based upon the

assessment 'score,' facilities are identifying residents who are admitted with pressure ulcers and/or residents who acquire pressure ulcers as low or moderate risk! If a facility assesses a resident to be at low or moderate risk and the resident subsequently develops skin breakdown, surveyors point to either inaccurate assessment of risk or ineffective prevention strategies. In either scenario it becomes next to impossible to make a case that the pressure ulcer was clinically *Un-avoidable*.

Even when the risk score has been computed accurately, the Guidance itself points out that reliance on a **risk assessment 'score' is not enough!** A resident whose overall 'score' may place them at moderate risk for pressure ulcer development may, in fact, have a high degree of risk in one of the assessment categories. This singular area of high risk could be diluted or obscured when you 'do the math.' The Guidance states that, regardless of any resident's total risk score, the facility **SHOULD** review each risk factor and potential cause(s) individually and determine whether targeted interventions need to be implemented. It appears clear that the **statistically validated assessment tool is not enough!**

How then can we make the assessment process **ENOUGH?**

After the assessment is performed using a validated assessment tool, **add a summary paragraph or section that translates the assessment and identified risk factors into resident-specific terms.** If the resident is identified as having mobility/functional ability issues, what are they, *specifically*? Is the resident primarily in a wheelchair, in bed with the head elevated? Are they capable of independent repositioning? If so, do they actually do it? Do they tend to slump to one side or slide forward? What body parts are particularly affected by these tendencies? Is the resident at risk from friction and shearing? Translate that into modes of transfer, independent, manual or mechanical. What does exposure to moisture mean for this resident *specifically*? If the resident has nutritional deficits, what is the severity of the nutritional compromise? What is the rate of weight loss or appetite decline? What are the probably causes, the prognosis and projected clinical course? Consider additional factors that may not be directly considered by the risk assessment tool such as: cognitive impairment, refusal/resistance to care, PVD, Diabetes, contractures, history of stasis ulcer and, very importantly, history of pressure ulcer.

The more comprehensively the risk factors are translated into resident-specific English, the easier it will be for the interdisciplinary care plan team to develop resident-specific prevention strategies. This translation/summary process will also ensure that the overall 'score' alone does not drive the prevention strategies, that the impact of reliability or scoring inaccuracies are minimized, and that areas of particular risk for the resident are not overlooked.

It can also protect facilities from surveyors citing inaccurate and/or inadequate risk assessment.

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