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**The Resident has a Fracture??  
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Skin Tears & Bruises:  
Incidental or Incident?**

**The Resident has a Fracture??**

The Illinois Department of Public Health (as in most other states) has indicated that it places a lot of importance upon the information presented (and NOT presented) when a facility reports an incident. Let's take a look at how best to report an injury when there may not have been an incident!

Ever experience the following scenario?

A resident is experiencing signs/symptoms of congestion or other medical issue. The MD orders the resident to have, i.e. a chest X-ray. In addition to verifying the diagnosis of pneumonia, to the facility's surprise the X-ray also reveals a fractured rib or clavicle or whatever!

This scenario is different from one in which a resident has had some type of reported incident, initially appears to be fine and is subsequently discovered to have a fracture. In the scenario above, there is no record of a recent incident and, at least initially, the fracture is an *injury of unknown origin*. As we know, 'injury of unknown origin' is one of the criteria that trigger the Abuse Reporting requirements.

Step One: Notify IDPH.

Forward a brief narrative indicating that an investigation has been initiated. The facility now has five days to complete its investigation and summarize its conclusions.

Step Two: Initiate a comprehensive investigation.

Interview the involved resident.

- If the resident is alert, oriented and reliable, their statement can substantiate that there was no identifiable incident or other event as well as verifying that the resident had not experienced pain/discomfort or other complaints that could have/should have been assessed or addressed by staff.
- If the resident is not able to report or respond to questions, it may be appropriate to interview other residents, i.e. roommate, tablemates, etc., regarding witnessed events or interactions with staff.

Review the medical record for a period of up to several weeks prior to the fracture discovery. The point is to look for clues that may assist in pinpointing a time frame or an event:

- Is there any documentation that suggests a change in the resident's physical ability to use the affected area? A change in resident participation in unit events/activities? A new-onset desire or need for more time in bed resting/napping? The change may have been minor and/or transient.
- Is there reference to observable changes, i.e. bruising, redness, swelling to the affected area? The change may have been minor and/or transient.
- Is there any indication of resident generalized complaints of pain/discomfort? Involving the affected area? Or increase in usage of existing pain medication regimen?
- Has the resident had any behavioral episodes including combativeness with staff and/or resistance to care?

Interview all staff who cared for the resident during the same time period as above record review.

- Pursue any potential or actual clues found as a result of the record review.
- If not, ask staff whether they observed any of the above during recent weeks. Direct care staff may have noticed a slight, possibly temporary, change in the resident but didn't feel it was significant enough to mention at the time.
- Verify that there were no witnessed falls or other types of incidents in recent weeks. Staff may not realize that they are to report cases of 'avoided falls' or an assisted slide to the floor in lieu of a fall.
- Ask about any care events during or after which the resident acted/responded unpredictably or atypically. Did staff have difficulty with a transfer, did the resident resist care or pull their arm away suddenly.
- Have staff share their knowledge of the resident's care plan interventions.
- Have staff perform return demonstration of various care techniques used with the resident, i.e. transfer, positioning/repositioning in bed/chair, etc., to determine whether care was rendered in accordance with the resident's care plan, facility policies/procedures, and with clinical standards of practice.
- Interview staff from other departments who are regularly assigned to the resident's unit.

For the purpose of this exercise, let's assume that all of the above avenues of inquiry lead to dead ends.

**The facility does not know how the fracture occurred!**

The facility could simply follow-up with a summary report to IDPH indicating that the injury remains of unknown origin.... But I wouldn't suggest it.

Step Three: Based upon the above recommendations for conducting a comprehensive investigation, the facility may not know how the fracture *did* happen but your investigation summary should assert/emphasize **HOW THE FRACTURE DID NOT HAPPEN!**

- Statement from the alert resident as to absence of incident or event, absence of pain, etc. (if applicable)
- There were no observations by other potential witnesses of incidents, questionable care events or interactions with staff.
- Medical record substantiation that there were no changes in resident abilities, participation, changes from baseline, signs/symptoms, etc.
- Absolute verification that there were no recent falls or other types of incidents.
- Absolute verification that there were no behavioral occurrences, combative episodes or resistance to care.
- Assurance that all involved care staff were aware of resident's care plan interventions.
- Substantiation, through return demonstration, that care was rendered in accordance with the resident's care plan, facility policies/procedures, and clinical practice standards.

Therefore the facility has ruled out abuse and incorrectly or inappropriately rendered care techniques by staff as causal factors.

Step Four: It is further recommended that the investigation summary report to IDPH suggests one or more clinically feasible potential causes:

- Consult with the attending physician and/or Medical Director as to type/nature of the fracture. Is it feasible that the fracture was spontaneous/pathological in nature? Is it feasible that, given the resident's overall condition, that the fracture occurred during normally/appropriately rendered care or during the resident's customary participation or activities?
- Review the resident's medical diagnoses and current medications, i.e. osteoporosis, osteoarthritis, cortisone therapy, etc.
- Does the resident have history of previous fractures? In the vicinity of the current fracture? If so, does this speak to heightened vulnerability?
- Is it possible that the resident was involved in an incident, i.e. a fall, but is physically able to get up independently from the floor yet is cognitively unable to report to staff?

In scenarios such as this, it is preferable for the facility to definitively *rule out* causes of the fracture and speculate as to potential causes than to have a surveyor definitely *rule in* a Level G deficiency!

## **Skin Tears & Bruises: Incidental or Incident?**

Facilities know that resident falls, with or without injury, require an incident report, should be investigated for cause/probable cause, and care plan interventions should be developed to prevent reoccurrence. There are still some facilities, however, that do not realize that the same principles and courses of action should be applied in the case of skin tears and bruises. In the case of more minor skin tears (those not requiring sutures) and bruises that are relatively small in size especially, the presence of these types of injuries are frequently being documented in nursing progress notes only.

Why is this a problem?

Skin tears/bruises are not care planned events, rather they are negative resident outcomes! Therefore their occurrence meets the criteria of 'incident.' When an 'incident' occurs, an investigation of its cause/probable cause is required by the regulations in order to develop meaningful corrective actions to prevent reoccurrence. When a facility does not treat skin tears/bruises as incidents, this process does not

take place. Nursing progress note documentation typically includes staff observation of the site, a description of the injury, and any treatment rendered. Therefore there is no documented evidence of an investigation (because there wasn't any) and there is no evidence of preventative care planning (because there wasn't any). The result: Residents sustain repeated skin tears and/or bruises.

Surveyors consider skin tears and bruises to be incidents. Triggered by reading a nursing progress note entry, the surveyor may request to see the accompanying incident report. Especially in the case of repeated entries involving skin tears/bruises, the surveyor will review the resident's care plan for preventative interventions. When a facility does not treat skin tears/bruises as incidents, the surveyor will not find an incident report or any care plan interventions.

No incident report means no investigation.

No investigation means no identified cause or probable cause of the injury.

No cause or probable cause means injury of unknown origin.

Injury of unknown origin means abuse must be considered as a possible cause.

Possible abuse means an abuse investigation with all the required reporting/notifications should have taken place.

The result: The facility sustains deficiencies.

Deficiencies involving uninvestigated/unreported skin tears and bruises have been cited at the *G-Level* under the Abuse F-Tags and, in the case of multiple resident examples, at the *H-Level* under F324.

Not interested in this article because your facility *does* document skin tears/bruises on incident reports? Before you take aim at the circular file...

Is the skin tear/bruise merely documented on an incident report or is there an investigation that results in the determination of cause/probable cause of the skin tear/bruise?

Caution: 'Fragile skin' or 'on Coumadin' are NOT causes of skin tears/bruises. They are definitely factors that put a resident *at risk* for skin tears/bruises but are not the singular reason why the resident sustained an injury today. And, being at risk for something does not imply that the something has to happen.

If there is a determination of cause/probable cause, does it result in the development of meaningful (and documented) preventative care plan interventions?

This is the point at which the rubber hits the road. Staff who attribute bruising solely to the use of Coumadin, for example, don't go any further. The resident needs to continue on the medication, the medication makes the resident susceptible to bruising, so bruising must be expected. End of story. Right?

NO! Surveyors expect, and the resident deserves, communication to/awareness of direct caregivers of the resident's risk factors and interventions that minimize the occurrences of bruising, i.e. extra caution when moving/positioning extremities, padding objects in the environment, and other interventions specific to the resident's activities, actions, and customary patterns.

Likewise, while there are numerous 'generic' interventions that address, i.e., 'at risk for injury related to fragile skin, that can be helpful in minimizing the occurrence of skin tears, it is important to include interventions specific to the involved resident. For example, the resident with fragile skin habitually forces their leg through the elevated foot pedals and sustains skin tears to the lower extremities. Or the resident with fragile skin who, when self-propelling their wheelchair, has difficulty making turns into their room and repeatedly scrapes their elbows.

Are preventative care plan interventions reviewed, modified, added following each occurrence?

If the interventions weren't successful in preventing another occurrence or the circumstances of the new occurrence are different from previous ones, then staff need to implement additional

and/or new ones. If they don't the resident will continue to be injured... and the surveyors will continue to write deficiencies.

Increased risk for skin tears and bruising may be an anticipated part of the aging process but *risk* does not have to become *reality*.

## Water, Water Everywhere...Is it enough?

*F327 requires facilities to provide each resident with sufficient fluid intake to maintain proper hydration and health and to ensure that each resident receives sufficient amounts of fluids based upon individual needs to prevent dehydration.... The amount needed is specific for each resident and fluctuates as the resident's condition fluctuates...*

The risk factors below are the ones most commonly faced by facilities and chronically difficult to address.

- Functional impairments that make it difficult to drink, reach fluids, communicate fluid needs.
- Dementia in which residents forget to drink or forget how to drink.
- Refusal of fluids.

How then could/should facilities begin to develop a comprehensive yet doable hydration program that meets the specific needs of each resident?

**1. The dietician will calculate each resident's daily fluid requirements. (A general guideline: body weight in kilograms x 30 cc's).**

The resulting number of cc's of fluid required by a specific resident when compared to the average number of cc's of fluid provided among the three meals served daily (see Step #2) will identify the potential *additional* fluid opportunities necessary to fulfill a specific resident's individual daily fluid requirements.

**2. Determine the average amount of fluids that are provided by dietary among the three meals served daily.**

The resulting number of cc's will establish general parameters upon which to determine the potential *additional* fluid opportunities necessary to fulfill the resident's specific individual daily fluid requirements as calculated in Step #1.

Comment: If the average amount of fluids served among the three daily meals is less than 2/3 of the daily amount of fluids required by the "average" facility resident, then the onus on other departments including nursing, activities, etc., to compensate with additional fluids becomes much greater. Each facility must therefore examine whether, within the context of its available resources and limitations, it is more reasonable to increase the amount of fluids automatically provided among the three daily meal trays or to increase the number and types of fluid opportunities provided by nursing, activities, etc. (Please note: The '2/3' is *my* boundary number, not a regulatory guideline, and is based upon practical experiences when assisting facilities in designing hydration program models)

**3. Complete a Dehydration Risk Assessment form on each resident (upon admission/readmission and quarterly thereafter).**

This assessment will identify each resident's level of risk for dehydration/less than optimal hydration (low, moderate, high) and the factors contributing to that level of risk.

Once the factors contributing to a specific resident's level of risk are identified, realistic and effective hydration strategies can be developed to meet that resident's individual needs.

**4. Program Strategies:**

- a. The scope of the strategies required in a facility's general hydration program is dependent upon the gap between the average amount of fluids provided daily among the three meal

trays and the daily fluid requirement of the ‘average’ resident. (A good estimate of the ‘average’ resident can be obtained by averaging the resident population’s body weights and/or the daily fluid requirements as calculated by the dietician in Step #1. Using 120-130lbs as an average is probably a safe option also.) If the gap is 1/3 or less than the average daily fluid requirements, general strategies can include fluids provided during activities, a full glass of water provided during medication administration passes, hydration cart rounds at designated intervals, water pitchers at each bedside, (**Please see additional comments about water pitcher below**) etc.

- b. Resident-specific strategies should be developed based upon level of risk and identified risk factors. Residents identified at low and many at moderate risk for dehydration/less than optimal hydration will probably be adequately addressed by the strategies included in the general hydration program. Residents at high risk, especially those with cognitive impairments, will probably need more individualized interventions in addition to the general hydration program strategies, i.e., more opportunities involving lesser amounts of fluid at a time, and/or alternative sources of fluids, i.e., gelatins, popsicles/ices, etc.  
**Water Pitchers:** As F327 does not contain a requirement for water pitchers in resident rooms, if sufficient alternative hydration opportunities are available to the above at-risk physically/cognitively impaired resident, i.e. with meal trays, during activities, during afternoon hydration cart rounds, etc., it may not be necessary to have the filled water pitcher at that particular resident’s bedside. F327 does however include the following instructions to surveyors *if* sampled residents show clinical signs of possible insufficient fluid intake: *What care did the facility provide to reduce risk factors and ensure adequate fluid intake, i.e. Keep fluids next to the resident at all times and assisting or cuing the resident to drink?* Clearly, the words ‘water pitcher’ are not included in the probe. On a practical level though, if an at-risk resident spends considerable time in their room, a water pitcher is an effective approach to keeping fluids next to the resident at all times. In fact, filled water pitchers at each bedside are a fairly common component of facilities’ hydration programs. However, if a resident is physically and/or cognitively unable to independently access the pitcher and cup, this strategy becomes meaningless unless staff are inserviced and reinforced to routinely provide fluids during care episodes with that resident. **Bottom line:** if your residents appear well hydrated, surveyors won’t be focusing on the presence or absence of water pitchers. If there appears to be a problem with hydration, surveyors may question why you don’t have water pitchers... and they will question your overall hydration program as well.

## 5. Documentation:

### a. Care Plan:

Problem statements can be phrased as ‘At risk for Alteration in Hydration’ or ‘Potential for Alteration in Hydration’ depending upon the resident’s assessed level of risk. Goal statements should include the resident’s daily fluid requirement. Interventions should include the average/approximate number of cc’s provided on the resident’s meal trays and a list of the additional fluid opportunities included in the general hydration program. If the resident is at high risk for alteration in hydration, additional specific interventions and related strategies should also be included.

### b. Monitoring:

It is highly recommended that residents’ consumption of foods and fluids be documented daily for all three meals and other fluid opportunities. This provides the information needed by the care plan team to determine the effectiveness (or not) of the interventions. It also provides substantiating documentation to a surveyor that the resident is being provided (and consuming) the appropriate amount of fluids daily. Translating the actual amounts into percentages or All-Good-Fair-Poor should be satisfactory for the majority of residents. This form of documentation allows for identification of trends/patterns and

changes from baseline without unduly burdening direct care staff. It is very unlikely that staff will be able to comply with strict intake (in cc's) documentation and the facility then opens itself up to deficiencies. In cases of residents at very high risk and/or for whom multiple strategies have been unsuccessful it may be necessary to document fluid intake in cc's.

Optimal hydration is a must for healthy living. Is your facility's hydration program one that your residents and staff can swallow?

**About the Author:**

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*For questions about the contents of this newsletter, contact Jacque Thornton, at the Aging Services of Georgia office at 404-872-9191.*

