

Fall Prevention

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Purpose of risk management recommendations

OMIC regularly analyzes its claims experience to determine loss prevention measures that our insured ophthalmologists can take to reduce the likelihood of professional liability lawsuits. OMIC policyholders are not required to implement risk management recommendations. Rather, physicians should use their professional judgment in determining the applicability of a given recommendation to their particular patients and practice situation. These loss prevention documents may refer to clinical care guidelines such as the American Academy of Ophthalmology's *Preferred Practice Patterns*, peer-reviewed articles, or to federal or state laws and regulations. However, our risk management recommendations do not constitute the standard of care nor do they provide legal advice. Consult an attorney if legal advice is desired or needed. Information contained here is not intended to be a modification of the terms and conditions of the OMIC professional and limited office premises liability insurance policy. Please refer to the OMIC policy for these terms and conditions.

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Mrs. B, a 73-year-old woman with a number of medical conditions, came to her ophthalmologist's office for an eye assessment. She was asked to sit on a stool with wheels for the exam. She slipped off, landing on her tailbone. X-rays revealed a possible hairline fracture of her spine. When Mrs. B suffered bruising and ongoing pain, she filed a claim against her ophthalmologist. She never regained the ability to walk and died nine months later. Her claim settled for \$60,000.

More than one out of four people 65 and older fall each year, and more than 3 million of them are treated in emergency departments for fall injuries, according to the Centers for Disease Control (CDC).¹ In 2016 alone, 30,000 older people died after their fall. The risk of falls stems from intrinsic factors related to the individual, such as age, health problems, and medications. Or falls can result from extrinsic, environmental circumstances such as wet floors or poor lighting. A fall compounds the burden of pre-existing health problems and can precipitate an inexorable decline. Indeed, many older people who fall die within one year of the mishap, like the patient discussed above. Many of these falls occur in the home. When they happen in physician offices and ambulatory surgery centers (ASCs), some patients and their families assume that physicians and staff members should have predicted and prevented the falls, and sue for malpractice.

OMIC published a study of our claims experience in 2015. We evaluated 50 claims and lawsuits involving 41 patients who have been injured during falls, about 1% of our claims since 1987. The patients who filed these claims are similar to those studied by the CDC: all but 10 of them were over 60, and four died, three within the first year after the accident. All but one of the 41 patients sustained significant injuries and faced unexpected medical costs; 25 had fractures, including of the skull, nose, arms, ribs, spine, hip, legs, and feet. The remaining patients had rotator cuff tears or serious soft tissue injuries to the head, hip, and upper and lower extremities. But were the falls due to negligent care? Could they have been prevented? In an issue of the *OMIC Risk Management Digest* devoted to falls, we examined the circumstances surrounding the falls, determined factors that increased their likelihood,

¹ STEADI (Stopping Elderly Accidents, Deaths & Injuries): Older Adult Fall Prevention
<https://www.cdc.gov/steady/index.html>; accessed 11/16/20.

and offered suggestions on ways to identify and assist those most at risk.² This document summarizes the risk management recommendations. That issue of the *Digest* contains additional case studies, an analysis of the difference between professional liability and premises liability claims related to falls, and information on money paid to settle these claims.

When is a fall the result of negligent care?

When patients sue their ophthalmologists due to falls, they usually allege that the fall should have been prevented by maintaining a safer environment, better assisting the patient, or both. Therefore, most investigations of fall claims will include not only an analysis of the patient's medical condition and the care provided by the ophthalmologist and staff, but also a review of the environment.

In their fall-related lawsuits, plaintiffs may allege professional liability (PL or medical malpractice) or general negligence (GL or premises liability). Professional liability is a type of negligence based on a breach of the standard of care in the performance of health care services. Premises liability occurs when a business owner does not adequately protect its patrons from hazards on the premises. Therefore, in order to determine whether a case is really a PL or GL claim, courts will often look at whether the patient was actually receiving medical care at the time of injury. They may also look at whether the service being provided requires special knowledge, licensing, or accreditation. This distinction is important for a variety of reasons that are explained in the **Policy Issues** article. Please see the online version of the *Digest* for that article.²

When and where do eye patients fall?

In an attempt to learn what can lead to falls, we analyzed both the patient characteristics associated with the falls, and the action that immediately preceded them (see Tables 1 and 2). Thirty of the 41 patients fell during or just after office visits; the remaining 11 fell at an ambulatory surgery center. After the patient's age, the most frequent intrinsic factor associated with a fall was the use of dilating drops: fully half of the patients who fell at the office did so after a dilated eye exam. Dilating drops are an essential aid to diagnosis. Yet they are known to cause temporary problems such as light sensitivity, glare, and decreased contrast sensitivity. These drops may be more apt to pose problems for older patients since it can take longer for their eyes to judge distance and depth, and to adjust to sudden changes from dark to light. Indeed, 10 patients fell when moving from the darker interior of the office into the brighter outdoors, including patients wearing sunglasses or transitional lenses.

Table 1. Intrinsic patient factors associated with falls in 41 patients

Older patient (≥ 60 years old)	31
Dilating drops	15
Use of an assistive device (e.g., wheelchair or cane)	8
Immediate postoperative period	8
Significant health issues	5
History of falls	3

The most frequent action leading to a fall was moving onto a chair or stool, or changing position while on one. Experts who reviewed claims involving falls from stools or chairs with wheels criticized their use, especially in elderly

² The articles include: "When patients fall, are doctors to blame?", "Liability and coverage for patient falls," and "Help patients reduce their risk of falling in your office or ASC." <http://www.omic.com/2015-v25-n2/>. Accessed 11/16/20.

patients who were left unattended. Standing up from a seated position precipitated six falls. Older patients may experience drops in blood pressure when standing up and thus feel faint. This is even more likely right after surgery involving sedation or anesthesia: eight patients fell in the immediate postoperative period. Older patients often do not have strong muscles in their abdomen or legs, and need to use their hands to push off from chairs to stand up. Younger ones who fell when getting up had vasovagal episodes after injection of fluorescein or minor eye procedures. Eight patients who used mobility aids such as canes, walkers, crutches fell, including four in wheelchairs while moving into or out of them.

Table 2. What patients were doing right before the fall

Trying to sit down or moving on a chair/stool	12
Moving from dark to light	10
Standing up from seated position	6
Transferring to/from wheelchair	4
Vasovagal reaction to procedure	3
Walking in office or in parking lot	3
Using the restroom after surgery	2
Faulty equipment (bed)	1

Ask a few questions to determine who is at risk

In response to the high number of older patients injured in falls each year, the Centers for Disease Control (CDC) developed a program called STEADI: Stopping Elderly Accidents, Deaths, and Injuries.¹ Many of the materials are geared to primary care physicians and include strength, balance, and mobility tests. Ophthalmologists in their offices and staff in ambulatory surgery centers (ASCs) are not likely to perform these tests as part of an eye exam or preoperative evaluation. The information in the documents does, however, contain recommendations that can be implemented by the eye care team.

One simple way to screen for fall risk is to ask the patient three questions proposed by the CDC. Some ASCs replace the CDC's third question with one about dizziness:

- Have you fallen in the last year?
- Do you feel unsteady when you stand up or walk?
- Do you worry about falling?
- Do you ever feel dizzy or lightheaded?

This last question can help identify younger patients who suffer vasovagal episodes in medical settings. Staff can either ask the questions and document the answers or include them on forms the patient completes, such as the one identifying who will drive them home after surgery or their emergency contact information. Some ASCs ask these questions when scheduling the procedure to help determine if the patient needs special assistance and may even need to be sent to a hospital for care. Any "yes" answer indicates the need for assistance and should be communicated to all members of the team providing care for the patient.

Watch for gait or balance problems and behaviors

Certain behaviors that are readily observed can point to unsteadiness and increased fall risk. Ask staff to watch for these behaviors and immediately go to the side of any patient who exhibits them:

- Pushing up off the chair by using one's hands

- Holding onto furniture when walking.
- Trouble stepping up to a curb
- Rushing to the bathroom
- Use of mobility aids
- Sadness

Using one's hands to push up off the chair, a sign of weak abdominal or leg muscles, could alert staff to stand next to the patient and provide assistance. Holding onto furniture when walking could indicate a fear of falling or weakness in the extremities. Trouble stepping up to a curb could stem from poor depth perception or muscular problems. Many patients experience urinary urgency and may fall while rushing to the bathroom. Offer these patients assistance to the restroom, especially after sedation or anesthesia.

Patients who use mobility aids such as canes, walkers, and wheelchairs are easy to notice. It can be hard to know when to help, however. Our claims experience shows that some may value their independence and decline offers of assistance. Respect the patient's choice but stay with the patient prepared to help until she has safely moved to where she is going.

It might be surprising to learn that patients who were sad or depressed are at increased risk of falling. Perhaps they are less attentive to their environment and don't notice obstacles or the approach of steps as readily.

Will getting answers to these questions and observing these behaviors prevent falls in ophthalmic practices and surgery centers? From the limited information available in the claims files we analyzed of the 41 patients who fell, at least 19 of the patients would have been considered at increased risk for a fall based on their history or behaviors. Asking the patient if he or she worries about falls or feels unsteady or light-headed could well have identified more.

Advise patients on how to avoid falls

Just as ophthalmologists and ophthalmic ASCs do not conduct formal gait and balance testing, they are not expected to provide extensive education on fall risk. But the eye care team can advise patients of simple ways to keep themselves safe:

- Stand up slowly
- Stand still a minute when you stand up
- Take your time
- Wait for your eyes to adjust before going outside

Consider placing signs with these reminders in the lobby or examination lanes. Prevent falls that can occur when standing up from a seated position by suggesting. Encourage your patients to "Stand up slowly" or "Stand still a minute when you stand up." When patients are offered sunglasses and prepare to exit into brighter light, remind them to "Take your time" and "Wait for your eyes to adjust."

Determine when to offer assistance

This review of 41 falls offers some guidance on which patients are likely to fall, and provides some screening tools. By asking some simple questions and watching for certain behaviors, ophthalmologists and the eye care team can identify those most at risk. The next step in fall prevention is to provide assistance. But which patients should be helped? Are staff in offices expected to escort each patient whose eyes have been dilated to the front desk? Should

they and staff at ASCs take all patients to their cars? Eye practices and ASCs clearly do not have the personnel to provide this kind of assistance. And while plaintiff attorneys have alleged this help was required and should have been provided, experts hired by defense attorneys to evaluate fall claims did not agree. They made it clear that staff should not be expected to assist patients who function normally outside the office, even if their eyes are dilated. They were critical, however, when the physician and staff did not provide monitoring and assistance for patients who had obvious difficulty ambulating and moving.

Back in 1992, OMIC Board member Dr. Monica Monica offered some “common sense safety tips” to minimize the likelihood of a general liability claim.³ Her suggestions on which patients to assist are still pertinent today.

- Watch and assist patients when seating them on stools. Make sure the rollers of the stool do not easily slide, carrying the stool out from under the patient. Stools with locking devices are preferable, especially when performing office laser procedures.
- Supervise and assist patients with mobility problems at all times when they are moving in and out of exam rooms or on and off chairs. This is especially important for individuals who are blind or have low vision.
- Stay with elderly patients in exam or treatment rooms.
- Encourage patients whose pupils have been dilated to stay in the office until they are comfortable with their vision. Provide post-mydriatic spectacles or drops to reverse dilation. Suggest that patients take a taxi home or arrange for a family member or friend to drive them.

Prevent injuries to staff

Ophthalmic practices and many ASCs do not have equipment to lift or move heavy patients. Physicians and administrators may be worried that staff may injure themselves by trying to assist bigger patients. These fears are well-founded. The CDC website’s section on workplace safety indicates that the healthcare industry has some of the highest reports of musculoskeletal injuries from what it calls “overexertion.”⁴ The single greatest risk factor for overexertion injuries is the manual lifting, moving, and repositioning of patients. According to the CDC, mechanical equipment, not staff, should be used to lift and move patients: there is no safe way to manually lift another human being. Let the ophthalmologist or head nurse know if you identify a patient who needs lifting or moving. The patient may need to be sent to a facility with the necessary equipment.

Make your office safe

Environmental circumstances were not a factor in the falls we analyzed. But time spent ensuring that the office is safe is always worthwhile. In the article cited above, Dr. Monica also provided suggestions on how to make the office safe.

- Make sure hallways are well lighted and free of obstacles.
- Make sure that office floor coverings are easily traversed by patients on foot, on walkers, or in wheelchairs. Discourage the use of area rugs, especially in patient pathways. Too often, the corners of these rugs dislodge and catch the patient’s footing.
- Ensure that pathways leading to the office and parking lot areas are well lighted and free of obstacles. Contact your landlord if lighting is a problem in your building.

³ Making Your Office Safe. Monica Monica, MD. *Argus*. <http://www.omic.com/making-your-office-safe/>. Accessed 11/16/20.

⁴ Safe Patient Handling. <http://www.cdc.gov/niosh/topics/safepatient/> Accessed 11/16/20.

- Determine if ramps are needed in entrance and exit areas.
- Routinely check equipment and office furnishings for loose fittings and unstable tables or chairs.
- Conduct an audit of your office. Keep in mind that the Americans with Disabilities Act (ADA) requires that public accommodations, which include physicians' offices, be constructed and altered to comply with the law's accessibility standards. Some of the recommendations and alterations to your office not only reduce your risk of liability, but also may be required by law.

Falls cause significant injury. This document offers some guidance on which patients are likely to fall, and provides additional screening tools. By asking some simple questions and watching for certain behaviors, ophthalmologists and the eye care team can identify and assist those most at risk.

Need confidential risk management assistance?

OMIC-insured ophthalmologists, optometrists, and practices are invited to contact OMIC's Risk Management Department at (800) 562-6642, option 4, or at riskmanagement@omic.com.