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Patient Falls: The Liability Landscape and Best Practices

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An online search for the phrase "slip and fall" returns a never-ending wave of advertisements for personal injury lawyers, premises liability insurance products, and risk management services. Absent from this deluge of results is any mention of medical malpractice. Ostensibly, this makes sense. Premises liability and medical malpractice are two separate and distinct categories of negligence.

However, when a patient falls in a healthcare facility or shortly after receiving treatment, the once bright line of demarcation between a premises liability claim and a medical malpractice claim can blur. Understanding the difference between these theories of liability and the obligations associated with each is crucial to protecting patients from injury and shielding providers from liability. Given the significant increase (estimated to be 46 percent per 1,000 patient-days) in the number of patient falls over the last half-century, this topic deserves renewed attention.[1]

Premises Liability v. Medical Malpractice

Premises liability (also known as "occupiers' liability" in some common law jurisdictions) is a type of general liability for negligence that occurs when a property owner fails to provide a reasonably safe space for guests, visitors, or patients. If a leaking pipe causes a patient to slip on a wet floor, it would be considered a premises liability matter. Healthcare providers are responsible for ensuring there are no trip hazards and for cleaning up ones that appear. This obligation is the same duty of care owed by homeowners and retail workers.

Alternatively, a fall may lead to a medical malpractice claim when a physician or healthcare provider fails to take necessary care to ensure a patient's health and safety. Common situations giving rise to such claims include:

- Misdiagnosis regarding a condition that affects balance or vision or that results in confusion or limited mobility.
- Failure to inform the patient of a medication's possible side effects or interaction with other medications.
- Failure to assess the patient as a fall risk despite the presence of factors indicating the patient is "at-risk."
- Failure to supervise patient properly following surgery.

Though both theories of liability are forms of negligence, significant procedural differences exist between the two causes of action. Medical malpractice lawsuits must satisfy particular requirements that include shortened limitations periods and strenuous pre-suit filing requirements. Premises liability suits are free from such constraints. Plaintiffs who incorrectly assume their injury is a premises case may risk having their claim dismissed for failure to timely submit an expert report or certificate of merit.

Consequently, a trial lawyer's safest course is to treat all patient falls as professional negligence claims and seek a definitive determination from the trial court later in the litigation process. Courts tasked with answering this categorization question examine the nature of the care rendered at the time of the fall. A case proceeds as a premises liability claim if the care is deemed custodial, routine, or non-medical. If the nature of the care is medical or

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professional care, the professional standard of care applies, and it is proper to litigate the dispute as a medical malpractice action.

Whether a particular activity involves medical or non-medical care depends on the nature of the activity, not on its purpose or the location where the activity was performed.[2] The following examples are a small sample of the ample case law that exists on this issue:

- Kastler v. Iowa Methodist Hosp., 193 N.W.2d 98 (Iowa 1971) (giving showers to psychiatric patients was non-medical care even though showers were given to make patients feel better).
- Toledo v. Mercy Hosp. of Buffalo, 994 N.Y.S.2d 298 (Sup 2014) (slip and fall on urine on hospital floor, five days after patient underwent heart surgery was non-medical care, since the fall did not occur during post-operative period in which physician's specialized knowledge would be involved).
- Trimel v. Lawrence & Memorial Hosp. Rehabilitation Center, 61 Conn. App. 353, 764 A.2d 203 (2001) (transferring patient from wheelchair to exercise mat in physical therapy facility during therapy session was medical in nature).

Addressing the Issue

While it is impossible to eliminate all patient falls, literature on the subject suggests that over 90 percent of hospital-based falls are preventable.[3] Establishing and implementing a comprehensive fall management program can help reduce fall risks and minimize liability in the hospital setting. Such programs consist of numerous proactive and reactive strategies. The Agency for Healthcare Research and Quality offers a host of tools, training, and research on preventing hospital falls, which are available online at https://www.ahrq.gov/topics/falls-prevention.html.

Regarding physician practices, the standard of care generally does not require implementing a comprehensive fall management program. Even so, when a patient presents as an obvious fall risk or discloses that they are susceptible to falling, physician practices should take steps to account for the fall risk and mitigate injury to the patient in the event a fall occurs.

All providers are strongly encouraged to use the following risk management techniques:

- Train staff to identify patients who present as a fall risk.
- Ensure that a patient's "at-risk" status is communicated at all handoffs.
- Closely monitor post-operative patients who are capable of ambulating.
- Implement an emergency plan which includes calling EMS in the event of a patient fall.

When providers fail to appreciate and plan for fall risks, patients are exposed to preventable harm. As the following case demonstrates, defending a lawsuit from this position is extremely difficult.

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Case Study

A 77-year-old male with a history of falls presented at the provider's office for shoulder surgery. The patient arrived wearing a back brace and using a cane. Immediately after the procedure, the patient visited the restroom without assistance or observation from the provider's staff.

While exiting the restroom, the patient fell and fractured his hip. The patient died a few days later. The patient's family filed a medical malpractice lawsuit against the provider, alleging that the patient's death was due to stress caused by the fracture.

The discovery process revealed several facts which negatively impacted the defense of the provider's actions. It came to light that the provider's staff failed to consider the patient's general instability and fragility, and failed to account for the patient's increased instability during the post-operative period. More concerning was the provider's post-fall documentation which indicated "no apparent injury with release." This determination was inconsistent with the EMT and hospital notes which documented an obvious displaced fracture.

The provider was left to argue that the standard of care did not require a formal patient fall assessment in this setting. Meanwhile, the patient's counsel was armed for trial with evidence that painted the provider as disinterested, detached, and inattentive. Against this backdrop, the provider agreed to settle this case before trial.

Numerous risk management teaching points can be gleaned from this case example, including:

- Post-operative falls which occur while the patient is receiving post-operative care are generally going to be deemed "medical" in nature.
- Damaging factual scenarios can impede defensibility even when there is an argument that the provider met the requisite standard of care.
- Planning for "at-risk" patients exhibits a commitment to patient safety and demonstrates that each patient's unique needs are accounted for.

Conclusion

Simply put, falls are a driver of claims within the healthcare industry. This trend is assured to endure as America's baby boomer generation grows older. Understanding and accounting for this risk increases patient safety and helps shield providers from liability. That said, even the most robust and disciplined patient safety protocols will not eliminate the issue. Providers should review both their general and professional liability policies to ensure they are adequately insured for all manner of patient falls.

Endnotes

1. Weil TP. *Patient falls in hospitals: an increasing problem.* Geriatric Nursing 2015 Sep-Oct;36(5): 342-7. doi: 10.1016/j.gerinurse.2015.07.004. Epub 2015 Aug 22. PMID: 26304626.
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3. Morse JM. *Preventing Patient Falls.* Thousand Oaks, CA: Sage Publications; 1997.

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