American Seniors Housing Association

Seniors Housing Legal Notes

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Defibrillator Use in Seniors Housing

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The proliferation of automated external defibrillators (AEDs) in public places, such as airports and shopping malls, is causing seniors housing providers and their residents to consider installing AEDs directly in their retirement communities. Some of the considerations include:

1. Whether there is a duty to provide an AED at a seniors housing property;
2. Whether use of an AED might lead to liability on the part of management;
3. Whether AED placement in a seniors housing community is practical and effective.

What is the Responsibility of a Senior Community to Provide an AED?

With AEDs now becoming commonplace in public facilities, residents of seniors housing communities may expect or demand to have AEDs available on the premises for the sake of quick response to a resident's cardiac arrest. Several states require that AEDs be placed in fitness clubs, sporting arenas, or schools and other public buildings. So far, however, it appears that no state law mandates that independent living residences, assisted living or even skilled nursing facilities provide AED services to their residents. However, all 50 states have enacted legislation promoting AED use, such as by (1) allowing laypeople to use AEDs, (2) providing limited immunity from liability for AED use, and/or (3) funding and distributing AEDs for use in public buildings and facilities.

While it is not yet the custom or practice in the senior housing business to furnish AEDs on the premises, AED advocates, residents, or residents' lawyers, might infer a duty from a given property's status or service program. For example, the American Red Cross Standard First Aid Course includes training in cardiopulmonary resuscitation and AED use. Therefore, if an assisted living or skilled nursing regulation or service contract includes a requirement or promise of first aid or CPR, it might be implied that AED services are included. Moreover, laws governing innkeepers and proprietors of facilities where the public is invited may establish a statutory duty to render aid to an injured customer. Indeed, outside the seniors housing area, plaintiffs have successfully sued for failure of a proprietor to have an AED available on the premises to respond to an emergency (e.g., a college, fitness club, amusement park and airline).

Potential Liabilities Associated with AED Operation

When working properly, an AED will detect a heart arrhythmia or cardiac arrest and apply an electrical charge necessary to restore the appropriate rhythm. Normally, an AED is relatively simple to operate and a layperson—even a child—can easily be trained to use one safely. However, an AED may fail to discharge if it is defective or improperly maintained. In addition, an AED can deliver a lethal shock to the user or a bystander if it is not used properly.

Every state has enacted a Good Samaritan law providing immunity from liability for certain AED users. Depending on the state, immunity may be available only if: (1) the person has completed a prescribed training course, (2) the AED user is a bystander who is not being paid for the service, and (3) no gross negligence or intentional misconduct is involved.

In California, for example, Good Samaritan protection is available only to someone who, without compensation, renders aid at the scene of an emergency. As a practical matter, therefore, a seniors community offering AED services would not

be eligible for Good Samaritan protection, and, if it maintains an AED, would need to accept responsibility for any liability arising from its use. In such a case, one alternative is for residents or a residents' association to organize a group of trained volunteers who would be eligible for Good Samaritan protection and available to respond to emergencies according to an on-call schedule.

AED Effectiveness in Seniors Communities

In the general population, AEDs used within the first minute or two after the onset of a cardiac arrest or arrhythmia can raise the chances of survival from under 3% to over 60%. However, the effectiveness of an AED declines rapidly with the passage of time (7% to 10% per minute).

Moreover, recovery potential after cardiac arrest in an elderly population may be significantly less than for other age groups. For example, one study found that under 2% of nursing home residents receiving CPR (which, unlike AED use, involves chest compression) survived to hospital discharge. Likewise, proposed California legislation to require AEDs in assisted living facilities was defeated, with the support of a geriatric medicine association, because of the relative ineffectiveness of AEDs on the frail elderly. On the other hand, AEDs may be far more effective for an independent living population whose health is not already compromised.

In a seniors housing community, the proper location of one or more AEDs requires considerable thought. Depending upon the size and configuration of the buildings and grounds, it may be impossible to have an AED located within a few minutes of every resident's potential cardiac emergency. In fact, most such incidents are likely to take place behind closed doors in the resident's apartment and be undetectable to a potential responder, so that an AED would be of no use at all. If AEDs are to be deployed, it makes the most sense for them to be placed in general assembly areas, such as dining rooms or recreational centers, where a witnessed cardiac event is more likely to occur.

Notwithstanding the complications referenced above, senior community residents are increasingly likely to expect or demand the availability of AEDs on site. In some cases, marketing considerations may even trump effectiveness and liability concerns. As prices come down (the average cost now is about $3,000) and public use becomes more widespread, owners and managers should give serious thought to the benefits and burdens of implementing an AED program.

About the Author:
Paul Gordon has represented over 250 seniors housing and care companies, facilities and investors since 1975 and practices exclusively in the area. He is the author of *Seniors' Housing and Care Facilities: Development, Business and Operations*, 3rd edition (Urban Land Institute, 1998) -- a 600-page volume with over 1,000 additional pages of business forms on CD-ROM. Paul has been on the Executive Board of the American Seniors Housing Association since 1995, and serves as its legal counsel. He is former chair of the Legal Committee of the American Association of Homes and Services for the Aging and the American Bar Association's Committee on Housing for the Elderly.

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