ICU Patient Falls Out Of Bed: Nurse Not At Fault; Hospital Faulted For Understaffing.

A ninety-two year old female patient was placed in the cardiac intensive care unit in a room with a window wall for observation. Her family was not allowed to stay with her.

She was getting Lasix for congestive heart failure and pulmonary edema. Both side rails of her bed were raised, but she was not restrained in bed. She began getting out of bed unassisted to go to the bathroom. She had been warned to the contrary. These incidents were fully documented in her chart by the nursing staff.

The attending physician visited the patient, read the chart and spoke with the patient. It was apparent to the physician that the patient was not oriented to the fact she was in the hospital, but believed she was in bed in her bedroom at home. Verbally reorienting her did not seem to help.

The physician decided not to order restraints for the patient.

The nurses continued to write chart notes to the effect the patient was at times oriented x3, but at other times stated she believed she was at home.

A few hours after the physician had visited and decided against physical restraints, the patient was found on the floor. She stated she thought she was at home, and wanted to go to the kitchen to prepare dessert for the family. She stated she was unable to get out of bed on the right side or on the left side, and so she had tried to get out of bed by crawling down to the foot of the bed and out.

She sustained a fractured right hip which required open reduction and internal fixation. The surgically repaired fracture healed unremarkably, and she was discharged to her home. However, she returned six months later with the same cardiac problems and died at the hospital. The hip fracture was not a factor in her death. After her death, the family filed suit seeking damages for the patient's fall, under a state law to the effect that the right to sue for personal injuries survives the patient's death and may be asserted by the family and heirs even after the patient has died.

The Court of Appeal of Louisiana accepted the jury's verdict that the attending physician had not departed from the standard of care in declining to order restraints for the patient.

The court went on to rule that the staff nurses were not negligent, during the seven and one half hours between the physician's visit and the patient's fall, for not having advocated in some manner for restraints to be ordered for the patient, even though it was apparent the patient was disoriented and it was probable she would try to get out of bed again.

However, the court did find the hospital itself negligent, on grounds of inadequate staffing. A nurse assigned to a patient in the cardiac intensive care unit was assigned solely to just one patient, due to the patient's need for close monitoring and for a ready response to any problem which might develop.

At the same time, the nurse was expected to respond to any code which came up in the ICU. Following hospital guidelines, the nurse left her patient to participate in a code, at the very same time her own patient was attempting to get out of bed, falling and fracturing her hip.

The court ruled the nurse could only be in one place at one time. She was not negligent for leaving her patient, pursuant to hospital directives, to participate in a code involving another patient. The hospital, however, was ruled negligent. **Merritt vs. Karcioglu, 668 So. 2d 469 (La. App., 1996).**

The hospital was negligent for understaffing the cardiac intensive care unit. A nurse was required to be in two places at the same time, i.e. watching her own patient, and responding to a code patient in another room.

COURT OF APPEAL OF LOUISIANA, 1996.

Patient Falls On Own Urine In Bathroom: Hospital Not Liable.

The patient had had a triple bypass operation ten day earlier. After some days in the cardiac intensive care unit after surgery, he was transferred to a private medical surgical room and was receiving physical therapy. About fifteen minutes after his physical therapist returned him to the chair in his room following therapy, the patient got up to use the bathroom.

He fell in the bathroom. There was a prompt response by a nurse and a nurse's aide to his bathroom call bell. They found him on the floor. There was urine on the floor and cuffs of the legs of his pajamas.

In his lawsuit against the hospital, the patient claimed negligence on the part of the hospital in that the floor of the bathroom was wet and glistening when he entered the bathroom that morning.

However, the hospital's housekeeping records indicated the room had not as yet been mopped that day. The patient could not produce a witness to substantiate that his bathroom had been mopped while he was with the physical therapist. Thus the Supreme Court of Alabama, in reviewing the record of the evidence from the trial court, was not able to conclude that the bathroom had been mopped and left in a wet and slippery condition as the patient asserted in his lawsuit.

The two caregivers who responded to the patient's call for assistance did state the bathroom floor was wet when they arrived. Their opinion was that the wetness was the patient's own urine, not soapy water or cleaning fluid left over from the room having been mopped by hospital housekeeping employees.

Assuming the bathroom floor was not unsafe in any way when the patient went in to void, the hospital could not be held legally responsible for a patient falling on his own urine. **Riverview Regional Medical Center vs. Williams, 667 So. 2d 46 (Ala., 1995).**