Patient Falls: No Bed Alarm, Court Awards Family $1 Million.

The quality-assurance incident report was admissible in evidence.

That is, after data was redacted from the report that no jury was meant to see, the incident report was properly given to the jury as evidence.

The basic facts must be revealed to the jury even if the incident report is the only place the hospital has recorded the date, place, time, names of witnesses, what happened, whether the patient was injured and knew she had fallen and whether restraints, a call bell or bed alarm were in use.

The deliberations and conclusions of the quality assurance committee are shielded by law under the privilege of quality assurance confidentiality.

The basic facts of what happened are not confidential information.

SUPREME COURT OF VIRGINIA
November 3, 2006

The seventy-nine year-old patient was admitted to the hospital with profound generalized weakness and new-onset confusion, disorientation, hallucinations, agitation and dehydration. She had been diagnosed with lymphoma ten years earlier.

The hospital's admission form was designed to prompt the nurses to check off a set of factors to assess the patient for fall risk. This patient, however, was not identified as a fall risk and no fall prevention measures were started for her.

A staff nurse raised only the top bed rails, put a call bell within the patient's reach and verbally instructed the patient not to get out of bed by herself but instead to use her call bell to ask for help getting out of bed.

The patient fell and broke her hip in the hallway just outside her room. After she died six months later from her lymphoma the family sued for her fall injury and got a $1,000,000 verdict which was upheld by the Supreme Court of Virginia.

The court accepted the testimony of a nurse who testified as an expert witness for the family that the patient should have been identified as a high fall risk.

Her fall-prevention plan, in the nurse/expert's judgment, should have included restraints or, better, a bed alarm which would have alerted the nursing staff if she got out of bed. There also needed to be a reliable system for nurses or other staff to respond promptly to the alarm going off indicating the patient was trying to get out of bed unassisted. **Riverside Hosp., Inc. v. Johnson, __ S.E. 2d __, 2006 WL 3106157 (Va., November 3, 2006).**