Fall: Jury Awards Damages For Nursing Negligence.

The patient, who had been a paraplegic for more than twenty years, was admitted to the hospital for pneumonia.

The day after admission he wanted to take a shower. The patient's nurse could not locate a shower chair in the hospital so the patient was allowed to have someone bring in his shower chair from home. It had suction cups but no wheels.

A nurses aide placed the shower chair in the shower in the bathroom and allowed the patient to attempt by himself to transfer from his wheelchair to the shower chair.

The patient fell, struck his head on the toilet and wrenched his shoulder causing a rotator cuff injury.

In the patient's lawsuit against the hospital the county district court judge directed a verdict that the hospital was negligent and allowed the jury only to decide the amount of damages. The jury awarded $3,000,000+ which the judge reduced to $1,000,000, the maximum allowed in Nebraska in a lawsuit against a government-owned medical facility.

The Supreme Court of Nebraska ruled the judge was wrong not to let the jury decide if the hospital was negligent and ordered a new trial.

The Supreme Court did review in detail the testimony that was taken into consideration by the district court judge.

Bathroom Too Small For Shower Chair, Wheelchair and Caregiver(s) Assisting the Patient

The patient's lawsuit alleged a violation of the Americans With Disabilities Act by the hospital, that is, failure to provide reasonable accommodation for his disability, as well as negligence, for the simple fact the bathroom was too small.

The patient testified his wheelchair was only partially in the bathroom itself and still partially in the doorway when he attempted to transfer by himself.

The nurses aide who placed the shower chair in the shower testified that after placing the shower chair in the shower she was standing by with the intent of helping the patient if he needed help.

However, there was not enough room in the bathroom for her to go in and be present and actually assist the patient as he attempted the transfer by himself.

The patient's nursing expert, a nursing instructor with a PhD, testified the hospital's nursing personnel committed violations of the standard of care.

They failed to have a reasonably safe environment for the patient, failed to comply with the Americans With Disabilities Act, failed to assess and monitor the patient properly and failed to assist in the transfer.

SUPREME COURT OF NEBRASKA
August 3, 2012

Hospital Policies for Patient Transfers

A nurse from the hospital, who was not involved with the patient's care, testified it was hospital policy for a single caregiver working alone with a patient to call for help if there was any doubt whatsoever whether the patient could be transferred safely.

The nurse testified the best practice to insure the patient's safety would have been to have transferred the patient to a wheeled shower chair in the hospital room where there was plenty of open space.

Two persons and a gait belt and possibly a mechanical lift could and should have been used to move the patient.

Then after he was safely and securely in the shower chair he could be wheeled into the shower, take his shower, be wheeled back into the hospital room and the transfer process repeated in reverse.

No Fall Risk Assessment

The nurse also testified it was hospital policy for all patients upon admission to have a fall risk assessment. There was nothing in the chart indicating that a fall risk assessment was ever done by the nurses with this patient.

Based on his paraplegia alone, the nurse testified, this patient would have been considered a high fall risk. **Green v. Box Butte Gen. Hosp., 284 Neb. 243, __ N.W. 2d __, 2012 WL 3137990 (Neb., August 3, 2012).**

Fall: Court Allows Patient's Case To Go Forward.

The fifty-three year-old patient was 5' 3" tall and weighed 200 lbs.

Her medical diagnoses included the brain disorder leukodystrophy, dementia, seizures and significant osteoporosis.

She was in the nursing facility for physical rehabilitation with the goal of restoring independent ambulation with a walker. She was a high fall risk, according to her admission nursing assessment, and her care plan expressly called for two persons to assist her with transfers.

When her daughter came to visit she found her mother sitting on the toilet in her bathroom. She had her mother pull the string to call for help. The aide who responded told the daughter the aide assigned to the patient had gone to lunch.

The aide tried to transfer the patient to her wheelchair. The patient landed on the floor with her leg twisted in front of her. The aide got another person and the two of them finally got her into her wheelchair.

An orthopedic expert is not required to prove that the patient's tibia and fibula fractures were caused by the fall and were not pathological fractures related to her osteoporosis.

APPEALS COURT OF MASSACHUSETTS
July 26, 2012

The Appeals Court of Massachusetts stated that the aide deviated from the applicable standard of care in three ways:

Trying to do the transfer alone when two aides were required by the care plan;

Failing to use a gait belt; and

Failing to lock the wheels of the wheelchair.

The Court ruled the lower court judge erred directing a verdict in favor of the facility. The patient did not call an orthopedist to testify as an expert but she did not need an expert to prove the fall caused her tibia and fibula fractures. **Pitts v. Wingate, 82 Mass. App. Ct. 285, __ N.E. 2d __, 2012 WL 3023983 (Mass. App., July 26, 2012).**