Patient Falls While Nurses Were Busy With Another Patient: Court Finds Negligence.

The Court of Appeals of Ohio ruled that the hospital's psychiatric specialty nurses were negligent and that their negligence was the legal cause behind the patient's injuries from her fall.

The jury's verdict which exonerated the nurses was thrown out in favor of a new trial before a different jury.

Patient's Medical History

The patient for some time had suffered from Parkinson's disease, scoliosis, osteoarthritis, osteoporosis and severe depression. Because of her depression she refused to eat, lost a considerable amount of weight and experienced severe dizziness and fatigue.

As treatment for her depression her psychiatrist admitted her to the hospital for electroconvulsive therapy (ECT).

High-Risk Fall Assessment

The patient's medical diagnoses, in and of themselves, would make her a prime candidate for a high fall-risk assessment while receiving hospital care.

In addition to that, the side effects of ECT can include headaches, memory difficulties, confusion and hallucinations.

Despite the risks, the physician's rationale for ordering ECT was to help the patient in the long run to recover from her depression, although it was predictable in the short term that ECT could actually contribute to her mental debility.

The court's rationale for pointing this out was that the patient's nurses should have been aware, or were aware, that her ECT treatments would tend to contribute to her already high fall risk.

Restraints Ordered

Two days before her fall her psychiatrist ordered a vest restraint because the patient was combative with staff and was hallucinating.

Going hand in hand with any order for a restraint is the requirement that the patient be closely monitored by the nursing staff. When not in her vest restraint in bed the patient was placed in a geri chair and positioned close to the nurses station to be watched closely.

The patient was a high fall risk. She was having ECT treatments. She was confused and had been hallucinating for several days.

The psychiatric special-care nurses should have expected the patient to be awakened and become agitated, confused, even delirious, from the noise and general mayhem created by a new psychiatric admit screaming in the room across the hall from her.

The nurses on the unit had been alerted that the new patient had already been placed in four-point restraints in the emergency room and would be coming on the unit in a highly agitated state.

All three nurses went to his room to admit him.

When the patient fell a few minutes after the new patient arrived, two of the unit's three nurses were still in his room and the two aides from the E.R., whom they could have asked to stay and help, had left.

The third nurse was not aware what was happening with the unit's other patients and could only guess what happened with her before she fell.

COURT OF APPEALS OF OHIO
April 21, 2006

Patient Transferred To Psychiatric Special Care Unit

The patient could not sleep and continued to hallucinate. Her psychiatrist believed this was a predictable side effect of her ECT and still wanted the ECT continued. She was taken in her vest restraint to her ECT, then transferred to the psychiatric special care unit, still in her restraint.

The court pointed out that the psychiatric special care unit had six patient beds and was staffed with three nurses.

Standard practice on the unit was for patient checks at least every fifteen minutes. The psychiatrist chose not to order one-on-one supervision. He did, however, discuss his concerns with the nurses about her confusion and hallucinations.

The patient's anti-depressant was increased and Haldol was added. The patient slept for most of the afternoon and evening without her vest restraint.

Nursing Negligence

The crux of the court's finding of negligence was that the unit's nurses were apparently paying all their attention to the admission of another patient, a highly agitated paranoid schizophrenic, when this patient fell in her room.

The nurses were alerted that he was coming. A highly agitated patient coming from the E.R. in four-point restraints was not an unusual occurrence on this unit.

The nurses checked all the other patients before he arrived and found them sleeping. Then all three nurses went to the new patient's room to admit him.

The court's opinion was the nurses should have anticipated that the ruckus from the new patient's arrival could awaken, startle and frighten an already confused and hallucinating patient sleeping across the hall without her restraint, causing her to fall trying to get out of bed.

At the actual moment the patient fell one of the nurses was no longer in the new patient's room. It was not clear why she was not checking the other patients. **McLaughlin v. Firelands Community Hosp. 2006 WL 1047499 (Ohio App., April 21, 2006).**