High Fall Risk: Bed Alarm Not Turned On, Court Finds Grounds For Lawsuit Against Hospital.

The eighty-six year-old patient was admitted to the hospital after she fell at home.

The hospital used a fall-risk assessment tool developed at Johns Hopkins Hospital. The patient's score was twenty-two. Any score higher than ten was considered high risk.

As a high-fall-risk the patient was supposed to be placed and she was placed in a bed with an alarm that sounds when the patient moves, to alert staff that the patient may be attempting to climb out of bed.

Because the bed alarm sounds with movement, an employee attending to the patient must turn it off before moving the patient in bed and must reset the alarm before leaving the room.

One of the hospital's nurses acknowledged in her testimony in a pre-trial deposition that making sure the alarm is activated on leaving the room of a high-fall-risk patient is absolutely important, one of the nursing "ABCs."

The night-shift personnel came on duty at 7:00 p.m. The patient was noted to be sitting in her chair then and was charted being put to bed at 8:30 p.m. The night nurse charted checking on her at 11:41 p.m. and again at 4:00 a.m. A nursing assistant charted vital signs that evening.

At 5:30 a.m. the patient cried out for help and was found on the floor next to her bed. She was injured. The bed rails were up. The bed alarm had not sounded.

The hospital's investigation revealed that the alarm was not turned on at the time the patient was found. The alarm was not broken, it worked properly.

No One Other than Hospital Employees Were in the Room During the Early Morning Hours

Even though the nurse and the aides who were working that night testified they recalled resetting the alarm when they left the room, the Superior Court of New Jersey, Appellate Division, ruled that there was no explanation for the patient ending up on the floor injured with the bed alarm turned off other than a hospital employee neglecting to turn the alarm back on after attending to the patient in bed.

The preventive interventions that were necessary for this high-fall-risk patient were proven in court by the very testimony of the hospital nursing personnel on duty that night.

The only probable explanation is that one or more of the hospital's employees failed to carry out their duty, that is, failed to see that the bed alarm was activated for this patient.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
January 30, 2013

We reported a prior ruling in this case in November, 2011: *Patient Fall: Nurse Did Not Turn Bed Alarm Back On.,* Legal Eagle Eye Newsletter for the Nursing Profession, (19)11, Nov., 2011 p.7.

The Court at that time refused to allow the patient's attorneys to add the nurse and aides as defendants in the case who cared for the patient that night, their names only having been learned after the chart was obtained by the patient's attorneys after filing suit against the hospital itself.

The statute of limitations expired before the attempt was made to add the nurse and the aides as defendants in the lawsuit, the Court ruled.

This time the Court ruled that the identity of the individual who actually left the alarm turned off was immaterial to the patient being able to go forward with a lawsuit against the hospital.

Just as there was no reasonable explanation for how it happened other than the bed alarm having been left turned off, there was no reason to doubt that it was a hospital employee who was responsible, no one else having gone into the room that night. **Ruday v. Shore Mem. Hosp., 2013 WL 331492 (N.J. Super., January 30, 2013).**

Documentation: Nursing Note Almost Sinks Hospital's Case.

The fifty-eight year-old patient was being treated in a VA hospital for complications of a diaphragmatic hernia sustained decades earlier as a result of combat trauma in the Vietnam War.

His physicians were watching him for signs of an adynamic ileus. Unlike the ileus that is not uncommon in post-surgical patients, digestive function does not return after a normal recovery period and distention and rupture of the stomach and intestines can lead to tissue death, vomiting, aspiration and cardiopulmonary stress in a patient with pre-existing cardiac problems.

A surgical resident ordered a clear liquid diet to be advanced as tolerated to full liquids, then to a regular cardiac diet.

The patient died from cardiac arrest secondary to gastric and colonic eventration through a left diaphragmatic hiatus secondary to right colon abdominal ileus.

The widow's lawsuit was based on a nursing progress note that appeared to state that the patient had eaten solid food which would have been highly inappropriate for him at the time the note was written.

A nurse charted that the patient had eaten 60% of his diet and 200 cc's of clear liquids.

UNITED STATES COURT OF APPEALS
FIRST CIRCUIT
February 12, 2013

However, the VA Hospital's experts were able to convince the judge that the ambiguous nursing note about the patient having "eaten" really only meant that he had consumed a portion of the liquid meal that the dietary records showed had been appropriately ordered for him.

No damages were awarded. The lower Federal court judge's interpretation of the nursing documentation, favorable to the VA Hospital, was not overruled by the US Court of Appeals for the First Circuit (Massachusetts). **Jackson v. US, __ F. 3d __, 2013 WL 500857 (1st Cir., February 12, 2013).**