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Positional Asphyxia: Patient Strangled In Restraints, Court Lets Lawsuit Go Forward.

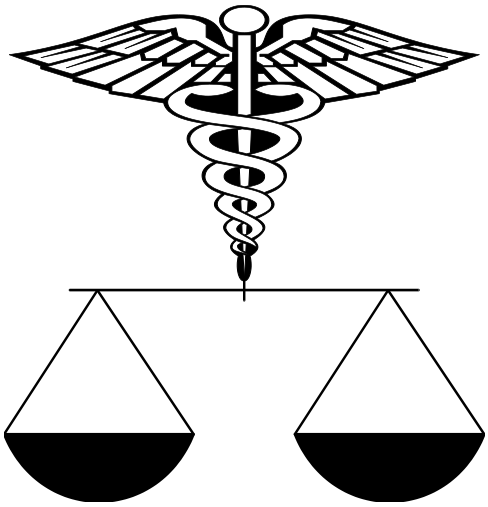
The deceased nursing home resident had suffered from multi-infarct dementia and diabetes.

She was a total care patient, requiring assistance with locomotion, dressing, eating, toileting and bathing. I n addition, her dementia impaired her judgment and reasoning ability. She had no control over her locomotive skills and was prone to sliding in one direction or another in bed.

According to the Supreme Court of Michigan, she was at risk for suffocation by positional asphyxia.

The nursing home's medical director authorized use of various physical restraints including the bed rails and a restraining vest that kept her from moving her arms, both of which were intended to impede her ability to slide out of position. There were also wedges or bumper pads ordered to be placed on the outer edges of the mattress to keep her from hurting herself by sliding down or entangling herself in the bed rails.

As the court pointed out, state and Federal regulations require that use of restraints of this type must be authorized by a physician. The rationale of the regulations, rather than patient safety, is to prevent overuse of restraints and excessive confinement.



The day before the resident was asphyxiated two aides found her tangled in her bedding, clothing and restraints and close to strangling herself in the bed rails.

The aides informed their supervisor of the problem, but despite this knowledge nothing was done to rectify the situation. That would amount to negligence.

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Resident Found Tangled
No Corrective Action

The day before the resident's tragic death two aides found her lying in her bed very close to the bed rails tangled in her restraining vest, gown and bed sheets. The aides untangled her and repositioned her. They repositioned the wedges to try to keep the resident from slipping into the gap that existed between the mattress and the bed rails.

The aides would later testify in court that they informed their nursing supervisor of the situation. They specifically told the nursing supervisor that the wedges were not staying put but instead were able to slide to the side. They were concerned if better care were not taken the patient could be hurt or even fatally injure herself.

The next day the resident was found to have slipped between the bed rails and the mattress. The lower part of her body was on the floor but her neck was wedged in the gap between the bed rail and the mattress.

She was not breathing and had to be rushed to a hospital. She never recovered. Two days later she was taken off life support and allowed to expire. The family sued the facility seeking damages for wrongful death.

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The family's case was thrown out by the lower state courts.

The grounds were that it was not a case of ordinary negligence but was a medical malpractice case, and because by the time the family could re-file the case as a medical malpractice case to comply with the judge's ruling that it was a medical malpractice case, the statute of limitations for medical malpractice had already lapsed.

The Michigan Supreme Court sent the case back to the lower court for jury trial.

Nursing Supervisor Was Notified
Omission To Act Was
Ordinary Negligence

The simplest rationale the Michigan Supreme Court could find to allow the case to proceed was that it does not take a medical expert to allow the jury to conclude that the nursing supervisor was negligent for not taking action when the two aides informed her of the problem.

The nursing supervisor's inaction in the face of an obvious hazard to a resident under her care was ordinary negligence. The lower courts were wrong to see it as malpractice and there was no issue with the statute of limitations.

Care Plan Did Require Expertise
Malpractice Seen

The court pointed out that even the simplest act of putting a dementia patient to bed requires a great deal of specialized professional expertise.

The Michigan Supreme Court recognized the family's expert witness as a true expert in this field by pointing to his co-authorship of *Deaths caused by bed rails,* 45 J Am Geriac Soc 797 (1997).

That journal article criticized the widespread use of bed rails without a clear sense of their role in the treatment plan and called for nursing homes to limit the use of bed rails out of concern for patients' safety.

The courts have been struggling to decide whether cases like this are better characterized as medical malpractice or ordinary negligence.

Medical malpractice requires proof through the testimony of a properly qualified expert witness. The family has at least one such witness on their side.

However, medical malpractice has a shorter statute of limitations than ordinary negligence.

If this is a medical malpractice case rather than an ordinary negligence case it has to be dismissed out of hand because the medical malpractice allegations were first raised more than two year after the patient's death.

Because of the confusion that has to this point existed in the courts as to how these nursing-home accident cases are to be characterized, it would not be fair to throw out this case even though many of the allegations raised by the family are for medical malpractice and were first filed after the statute of limitations to sue for malpractice had run out.

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However, in this particular case it would be for the jury to consider all of the evidence before deciding whether the combination of restraints, bedding materials, clothing, bed rails and the mattress fell below the professional standard of care for nursing personnel.

The court also saw an ongoing need for professional nursing and medical staff to re-assess and re-evaluate their patients as time goes on to be sure that the combination of restraints, bed rails and other materials is meeting their needs and not posing a safety hazard.

Staff Training
Ability to Recognize Hazard

The court discussed in general terms the obligation of nursing facilities to train their staff to appreciate the risk to dementia patients and other residents of positional asphyxia in the gap between the bed rails and the mattress in combination with restraints, bedding and clothing.

That will likely be a moot point in this case as it was the aides who brought the problem to their supervisor's attention, rather than the other way around.

Duty to Ensure Safe Environment

The court pointed to language in state and Federal regulations for long-term care which requires facilities to ensure that residents have an accident-free environment.

As other courts have done, the Supreme Court of Michigan declined to interpret the word "ensure" to mean that a nursing facility is strictly or automatically liable any time any accident happens to a resident. The family's lawsuit was ruled improper to the extent it relied on that erroneous interpretation of this language in the Federal regulations.

Instead, this language is only a statement of public policy that nursing facilities are expected to take all practicable measures for patient safety. Facilities will continue to be judged by the rules of negligence rather than strict liability in nursing-home accident cases, as far as this court is concerned. **Bryant v. Oakpointe Villa Nursing Centre, __ N.W. 2d __, 2004 WL 1724901 (Mich., July 30, 2004).**