Failure To Restrain: Jury Verdict Against Skilled Nursing Facility Thrown Out On Technicality.

The jury's verdict was $4,398,007.90 for the patient plus $952,000.00 for the patient's attorneys as attorney fees.

The jury during the trial was allowed to see a copy of the citations for violations of state and Federal regulations issued by the state inspectors. The California Court of Appeal ruled that that was prejudicial error by the trial judge and disallowed all but a tiny fraction of the money awarded in the jury's verdict.

In a civil lawsuit the jury is supposed to reach its own independent decision on the issue of negligence based on the evidence presented at trial and the expert witnesses' opinions. The jury was improperly swayed in the patient's favor by the ostensible authoritativeness of the state inspectors' conclusions, the Court believed.

Facts of the Lawsuit

The seventy-nine year-old patient was admitted to the skilled nursing facility for rehabilitation.

On admission he was assessed as mentally alert, but with difficulty standing and walking he was considered a high fall risk.

After his first fall the nurses noted him as having poor safety awareness/judgment and unsteady/poor gait, attempting to function beyond his ability and climbing out of bed/chair.

The plan was to put his bed in the lowest position, start a two-hour toileting program and review his medications.

After his second fall he was assessed as forgetful, impulsive and poor at utilizing a safety device. The plan was to make sure his walker was always within reach.

After his third fall a self-release lap belt was added along with a bed alarm.

He fell twice the same day two days later. A bedside commode with a urinal was provided. His family was asked to get him pants with a Velcro fly as he seemed to lose his balance while unzipping.

After his sixth fall he was confused but was very adamant about transferring and ambulating on his own. The bedside commode was taken away because he refused to use it.

The new plan was for constant monitoring, but he was not moved to a room where he could be seen from the nurses station.

The patient fell nine times at the facility.

His falls usually occurred when he tried to get out of bed on his own to use the bathroom.

After his seventh fall he had to be sent to the hospital for brain surgery for a subdural hematoma. He had a stroke after his surgery.

Back in the nursing facility from the hospital, he fell twice again.

The last time he fell it was an episode where he and his wheelchair went over backward while he was struggling to get out of his lap belt.

The facility was cited for violation of Federal regulations that require a nursing facility resident's environment to be as free as possible from accident hazards and require each resident to receive adequate supervision and assistance devices to prevent accidents.

Specifically, according to the state inspectors, the facility should have provided constant visual monitoring after his care plan was modified to require that, and the nurses were too slow to respond to his bed alarm, which tends to defeat the whole rationale for having the alarm.

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The patient's seventh fall was preceded by the bed alarm going off in the nurses station. Nurses arrived two minutes later and found him already in the bathroom. Even with two nurses in the room he lost his balance, fell and hit his head. He had to be sent to the hospital for surgery for a subdural hematoma.

Patient's Expert Witness's Testimony

The patient's expert witness testified that the patient should have been restrained for his own safety. Raised padded side rails would have been appropriate.

Facility's Defense Testimony

The facility administrator pointed out that after each fall the interdisciplinary team met and considered the issue of restraints, specifically side rails. The team considered side rails inappropriate because they believed the patient was mentally competent and could ambulate on his own.

The patient's own physician testified he did not believe restraints were appropriate because they can cause more problems than they solve, such as increased agitation in the patient and new problems with breakdown of skin integrity. Side rails in particular can be problematic because patients can try to climb over them and in doing so can fall from a level higher off the floor than the height of the mattress itself.

State Regulations on Use of Restraints

The Court of Appeals ruled that the trial judge correctly refused the facility's request to instruct the jury about certain specific regulations on use of restraints.

Restraints can only be used on the order of a licensed physician or other licensed professional the scope of whose license permits authorization of restraints.

Only certain "soft" restraints are permitted by state law in California.

Restraints in a skilled nursing environment cannot be used for behavior modification, as a form of punishment, for the convenience of staff or as a substitute for more attentive medical or nursing care.

However, reciting the applicable regulations was not relevant to the core question whether this patient's care met the standard of care, to which the jury's answer was in the negative. **Nevarrez v. San Marino Skilled Nursing, __ Cal. Rptr. 3d __, 2013 WL 2436633 (Cal. App., June 5, 2013).**