Unrestrained Stroke Patient Falls From Bed: Jury Rules Caregivers Not Negligent.

The seventy-four year-old patient had to be admitted to a hospital after her third stroke, a massive event which left her completely paralyzed on her right side.

After the hospital did all it could the patient was discharged to a nearby skilled nursing facility.

Hospital Discharge Indicated Occasional Use of Restraints

The evidence presented at trial in the Superior Court, Los Angeles County, California, included the patient's discharge summary from the hospital.

The discharge summary made reference only to "occasional" use of restraints in the hospital. "Regular" or "usual" use of restraints checked off on the discharge form would have put the nursing facility on notice of a potentially high fall risk.

The faulty data in the discharge summary was contradicted by testimony at trial that a Posey vest was used regularly in the hospital. However, that fact was not communicated to and was not known by the staff at the skilled nursing facility prior to the patient falling out of bed.

Close Monitoring After the Patient Fell

A CNA heard the patient fall out of bed at 2:00 a.m. and right away told the nurse. She checked and found a medium-sized bump on the patient's head, phoned the physician a little after 2:00 a.m. and he ordered hourly nursing neuro assessments.

After four such assessments, at about 7:30 a.m., the nurse phoned the physician, concerned the patient could not be roused. The physician sent her to the hospital for a CT scan which was delayed getting a family member's consent.

The patient had a subdural hematoma. The physicians deemed her injury untreatable and she was returned to the nursing facility and allowed to pass.

After looking at the pre-fall assessment and quick post-fall response, the jury found no negligence in the care given by the nursing facility. **Simon v. Sierra Madre Skilled Nursing, 2007 WL 685830 (Cal. Super., February 9, 2007).**

The patient's nurse did not complete the fall-risk assessment between the time the patient was admitted to the skilled nursing facility and when she fell.

However, had the fall-risk assessment been completed, the nursing assessment would have been that the patient, with complete right-side paralysis, was a low fall risk.

If the fall-risk assessment had been done and communicated to the facility's interdisciplinary team, the team would have recommended to the patient's primary-care physician not to write an order for restraints.

The overall treatment goal was to use the lowest level of restraint necessary for the patient, that is, to raise the bed rails or take other measures rather than impose a Posey vest while the patient was in bed.

After she fell, the patient was promptly and competently assessed and cared for by her nurses and her physician was promptly informed of the situation.

The facility was not negligent.

SUPERIOR COURT, LOS ANGELES COUNTY CALIFORNIA
February 9, 2007