LEGAL EAGLE EYE NEWSLETTER

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Bedrails: Court Rules Bottom Rail Was A Restraint, Caregiver Abused The Patient.

After a series of falls at home and then in the nursing home, an unlicensed caregiver decided to remodel the bedrails on the ninety-one year-old resident's bed.

Before the changes, the bed was positioned against a wall so that access and egress were possible only on the one open side.

The one bedrail at the top of the open side of the bed left plenty of room below it for the resident to get in and out of bed safely on his own.

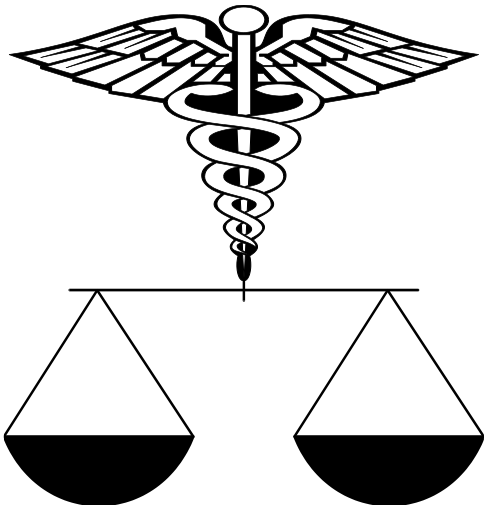
After a lower bedrail was installed there was a gap only about eighteen inches wide for the resident to attempt to squeeze himself through to get in and out of bed.

Days after the change was completed the resident was found on the floor with an obvious head injury from a fall.

The resident soon died from a closed head brain injury in the form of a subdural hematoma.

The investigation by the State resulted in the caregiver being found guilty of abuse of the resident. His name was added to the registry of persons who are disqualified from employment in direct patient care for having abused a vulnerable adult.

The Court of Appeals of Washington upheld the findings of the State inspectors and the administrative appeals that affirmed the caregiver's guilt and ruled that his name being placed in the registry did not violate his rights.



Upper and lower bedrails on the open side, with the other side of the bed against the wall, is considered a restraint, the same as if upper and lower bedrails were in use on both sides of the bed.

There should not have been a restraint in use. The physician did not order a restraint.

From in-service training the caregiver knew that physician authorization was required.

COURT OF APPEALS OF WASHINGTON
November 21, 2024

The Court reaffirmed the rule that bedrails are a form of restraint that cannot be employed by caregivers without a physician's order.

The Court did not elaborate on the parameters for a physician to order restraints because that was not relevant.

Basically, restraints can only be ordered for the patient's safety, and not as punishment or for staff convenience, and must be ordered only for a specific time.

In this case the Court pointed out that the facility itself had conducted in-service training for its caregiving staff, including the caregiver in question, instructing them that bedrails are a restraint and, like other forms of restraint, can be implemented only with permission from the physician.

In fact, the caregiver in this case had shared his plan with a charge nurse to remodel the resident's bed with an additional bedrail supposedly to mitigate his fall risk.

He was expressly told not to go ahead, but he did so anyway.

It was not elaborated upon by the Court, but it seemed the facility itself was not subjected to scrutiny by the State over this incident because the facility had done what was expected to educate and control its staff.

It was unfortunate that a rogue individual went ahead without authorization. **Caregiver v. Department, 2024 WL 4853528 (Wash. App., November 21, 2024).**

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