LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

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Patient Wanders: Court Looks At The Nursing Standard Of Care For Patient's Safety.

A nursing home resident who was diagnosed with dementia wandered into the room of another resident who had a known propensity for violence.

The resident was assaulted by the other resident. The court record is inconclusive as to the nature and extent of her injuries or whether they led to her demise.

The family sued the nursing facility for negligence.

At present the legal issue is whether the family's expert witnesses' qualifications and opinions will be accepted for the family's legal case.

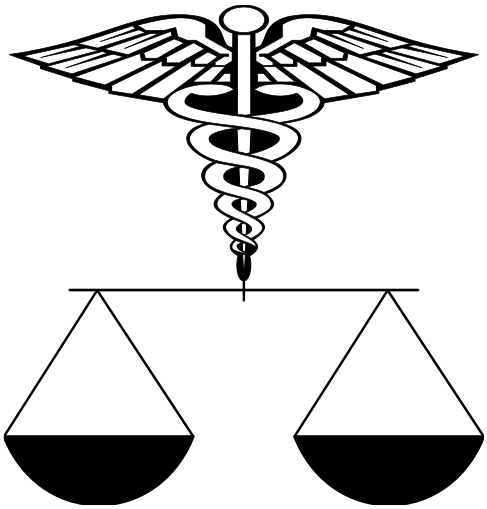
The Court of Appeals of Texas ruled the expert is qualified and has expressed a valid summary of the standard of care as applied to the facts of this case.

Expert Opinion Accepted As To The Standard of Care

The starting line in defining the standard of care is to point to the duty to anticipate wandering behavior from any patient with a diagnosis of dementia.

The general obligation to ensure patients' safety and wellbeing translates to a heightened need for close monitoring and supervision.

That means placing the resident in a room close to the nursing station so that it will be readily noticed when the patient is up and about, and fifteen minute checks should be ordered to account for the patient's whereabouts on a frequent basis.



As a general rule a physician is not considered an expert on nursing care and cannot testify against nurses in court.

The general rule of exclusion does not apply to a physician who has direct experience working with the nurses in the setting at issue.

This physician has collaborated extensively with nurses caring for wanderers in nursing facilities.

COURT OF APPEALS OF TEXAS
January 23, 2025

Problematic for the nursing home in this case was a recommendation that had been charted that this resident was to be moved to a room closer to the nurses station for close supervision, but the room change was never carried out.

The chart note about a room change being necessary amounted to an acknowledgement that the nursing home knew the resident required close monitoring and supervision, while that close monitoring and supervision was not provided.

The family's expert explained that he would have ordered fifteen minute checks for this resident, based on his experience.

Fifteen minute checks needed to be documented for a record that they were actually being done, for assessment of possibly necessary modification of the care plan and as valuable evidence in court.

It was also necessary for the care plan to reflect an obligation by staff members to chart specifically when they observed wandering behaviors by the resident.

That documentation would assist the treatment team in evaluating whether the measures in effect were effective.

Nursing staff should have documented for the benefit of all caregivers that this resident had a way of antagonizing others, which made it imperative to monitor her interactions with others for interpersonal safety. **Nursing Home v. Gierczak, 2025 WL 285335 (Tex. App., January 23, 2025).**

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