Fall: Court Wrestles With The Issue, Was Bed Alarm Required By The Standard Of Care?

The eighty-seven year-old patient was admitted to an Indian Health Service hospital operated by the US Government.

She came in by ambulance through the emergency room for problems associated with her heart condition.

The E.R. physician noted her diagnoses included atrial fibrillation, endocarditis, high cholesterol, high blood pressure and diabetes. He ordered a battery of medical tests, which did not reveal any new acute medical issues. He admitted her nevertheless because of her dizziness and lack of coordination while walking.

The patient told the admitting nurse that she was dizzy and had fallen four times at home. The nurse concluded that she was a high fall risk and decided that the facility's fall precaution policies were necessary and appropriate for her.

Facility's Fall Prevention Policy

The facility's fall prevention policy came practically *verbatim* from a commonly used nursing textbook.

All patients at the time of admission were to have an assessment to determine their fall risk. A score of eight or more on the specific scale in use (which was not identified in the court record) meant the patient was at high risk. The fall risk was to be entered on the adult admission database and on the nursing Kardex.

A fall prevention sticker was to be placed on the front of the chart.

Mention of the patient's fall risk was to be included in all nursing reports to the oncoming shift.

The patient's fall risk was to be explained to the patient and family along with education as to how the family could help.

The high-fall-risk patient was to be assigned to a room near the nurses station.

Side rails were to be kept up, call bell within reach and a fall risk patient was never to be left alone on the commode.

A night light was to be left on at night to assist the patient with orientation.

The patient was to be checked at least every two hours for bathroom needs.

The bed alarm or wheelchair alarm, if in use, was to be checked by the nurse to make sure it was on.

It is a question of fact for the jury whether the standard of care required the use of a bed alarm for this patient.

The jury will have to weigh the conflicting expert testimony and render a verdict one way or the other.

The patient's family's nursing expert's opinion is that a bed alarm was required, based on her expertise and training as a nurse, her research of nationally published standards and her review of this patient's medical records.

The hospital did not hire an outside expert but relied instead on the opinion of a physical therapist who was employed at the hospital and had worked with the patient herself the day before the patient fell.

Her opinion is that a bed alarm was not necessary with this patient because she showed no cognitive deficits that pointed to the need for a bed alarm.

The patient rang her call light during the early a.m. hours, waited for a nurse, was escorted to the restroom and back to bed just minutes before a nurse heard something, went to the room and found her on the floor with a fatal injury.

UNITED STATES DISTRICT COURT
SOUTH DAKOTA
April 29, 2013

The Patient's Fall

Three days after admission, in preparation for discharge, the physical therapist was called in to assess the patient's level of mobility and to instruct her, if necessary, in the use of a walker.

The physical therapist found that the patient's balance had improved and that she could get in and out of bed, stand up from a chair, get on an off the toilet and walk at least one-hundred feet with her walker, all without assistance.

The afternoon before she fell the nurses noted the patient was alert and oriented and was consistently using her call light when she needed to get out of bed.

At 4:00 a.m. she pushed her call light, waited for a nurse and was assisted to the restroom and back to bed.

The patient's nurse charted the 4:00 a.m. encounter with a progress note that the patient's gait was steady with her walker and that she was oriented x3, that is, oriented to person, place and time. Then the nurse went on her break.

Moments later another nurse heard something and went to the room. The patient was on the floor. She had a head contusion, so the E.R. physician was called. Scans and x-rays were ordered. Because the patient was on a blood thinner the bleeding inside her skull was accelerated. The physician called a neurosurgeon at the nearest trauma center and had her transferred, but she passed away two days later.

Standard of Care

The US District Court for the Southern District of South Dakota saw from the facts of the case that the hospital's nurses, despite the unfortunate outcome, had done just about everything that was called for.

The only open question was whether a bed alarm should have been in use with this patient. Although numerous sources in the literature, recommendations from the US Centers for Disease Control and Prevention and the Joint Commission's Patient Safety Goals urge caregivers to use bed alarms, there is no hard and fast rule that a bed alarm must be used with every high fall risk patient, the Court said. In court it comes down to a battle of the experts and the jury will have to decide. **Wierzbicki v. US, 2013 WL 1796964 (D.S.D., April 29, 2013).**