LEGAL EAGLE EYE NEWSLETTER
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Fall: Nurses Followed Facility's Procedures, Court Finds No Nursing Negligence.

The patient was in the hospital being evaluated for right hip pain.

His treatment regimen included narcotic pain medication.

He fell after he got up from bed without calling for help and tried to walk to the bathroom unassisted.

While attempting to grasp the bathroom door to steady himself, the door closed on his hand, necessitating a partial medical amputation of one of his fingers.

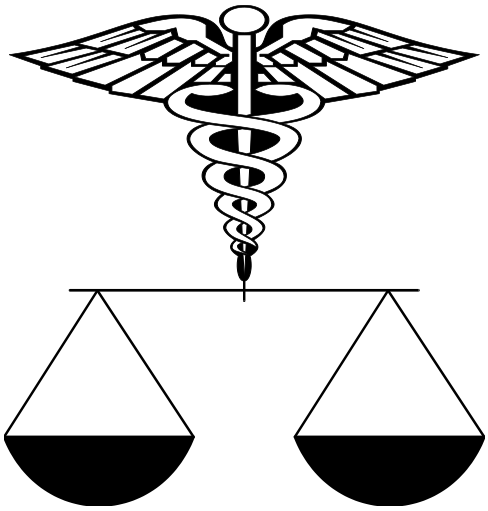
Court Finds No Nursing Negligence

The patient and his wife sued the hospital for nursing negligence. The Court of Appeals of Kentucky dismissed their case.

The Court based its decision on the testimony of two nurses who cared for the patient.

The nurses testified they followed the hospital's standard procedures. They carefully evaluated the patient's potential for injury from a fall, designated him a high fall risk and then adopted a standard care plan.

The hospital's standard basic fall prevention plan for a high-fall-risk patient required tagging the patient with a special yellow wrist band, tagging his room door with a yellow star and outfitting the patient with yellow non-slip socks with rubber grips on the bottom, all of which was done.



While this patient was a high fall risk, he was conscious and not helpless, could request assistance, had some ability to ambulate independently and had not previously fallen at the hospital.

The nurses' testimony does not show any violation of the fall prevention plan in the nursing care this patient received.

COURT OF APPEALS OF KENTUCKY
December 24, 2014

In addition, the patient's top bed rails were raised in compliance with the hospital's standard safety protocols.

Raising the bottom bed rails in addition to the top rails was not done because that was deemed a restraint which required a physician's order, and the nurses had no physician's order for the bottom bed rails for this patient.

At the start of every shift the nurses reassessed the patient's fall risk, checked whether he was still wearing the appropriate non-slip socks, reminded him to call for assistance before getting out of bed and made sure his call button was within his reach.

From the nurses' testimony it appeared to the Court the legal standard of care was fully met by the patient's nurses.

In a nursing home setting a patient might well require additional fall-prevention measures like a walker or a bed alarm or the bottom bed rails raised as a restraint, but there is no evidence such preventive measures were called for here with this patient before the fact.

This patient's attorneys did not have any expert nursing testimony that any fall prevention measures were necessitated beyond those in this patient's fall-prevention plan. **Martin v. Our Lady, 2014 WL 7339265 (Ky. App., December 24, 2014).**

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