Fall Care Plan: Documentation Was Missing That Plan Was Carried Out.

An eighty-six year-old Alzheimer's patient fell in a nursing home and fractured her hip.

The patient's family had placed her in this particular facility because it had a philosophy against unduly restraining Alzheimer's patients, even those prone to injury from falling due to physical infirmity, mental confusion and memory loss.

The patient's lawyers complimented the facility for its no-restraint philosophy, but argued that the nursing and medical staff still should have seen the need for a bed alarm, a lower bed and/or cushioned mats on the floor near the bed to reduce the risk of injury from a fall.

The facility countered that it had a perfectly good fall-care plan, that is, the doctor's orders in the patient's chart required staff to check on her at least every two hours, yet the facility did not fully explain how checking her every two hours would have prevented her from falling .

Poor Nursing Documentation = Poor Nursing Care

Nevertheless there was no documentation in the chart that the fall-care plan, such as it was, was being implemented, that is, there was no documentation of the two-hour patient checks ever being done by her caregivers.

Incomplete nursing documentation sends a message to a jury that the patient's care needs are being neglected, even if there is no direct, concrete cause and effect relationship between the care that cannot be documented and the actual injury to the patient which resulted in the lawsuit.

The patient's lawsuit in the Court of Common Pleas, Philadelphia County, Pennsylvania resulted in a $500,000 jury verdict in her favor. **Logan v. New Courtland Elder Services, Inc., 2007 WL 2491724 (Ct. Com. Pl., Philadelphia Co., Pennsylvania, June 19, 2007).**