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# LEGAL EAGLE EYE NEWSLETTER

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*For the Nursing Profession*

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## Positional Asphyxia: Patient Strangled In Restraints, Court Lets Lawsuit Go Forward.

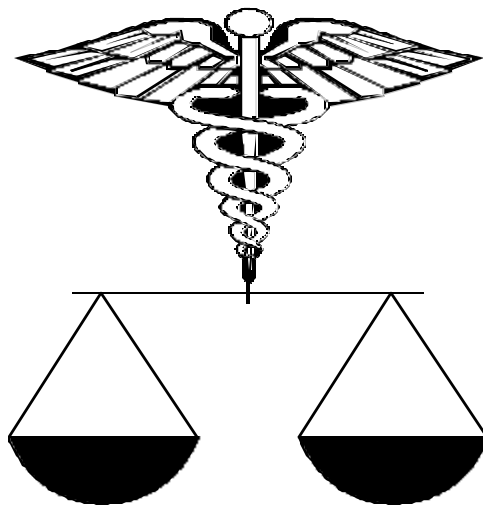
The deceased nursing home resident had suffered from multi-infarct dementia and diabetes.

She was a total care patient, requiring assistance with locomotion, dressing, eating, toileting and bathing. In addition, her dementia impaired her judgment and reasoning ability. She had no control over her locomotive skills and was prone to sliding in one direction or another in bed.

According to the Supreme Court of Michigan, she was at risk for suffocation by positional asphyxia.

The nursing home's medical director authorized use of various physical restraints including the bed rails and a restraining vest that kept her from moving her arms, both of which were intended to impede her ability to slide out of position. There were also wedges or bumper pads ordered to be placed on the outer edges of the mattress to keep her from hurting herself by sliding down or entangling herself in the bed rails.

As the court pointed out, state and Federal regulations require that use of restraints of this type must be authorized by a physician. The rationale of the regulations, rather than patient safety, is to prevent overuse of restraints and excessive confinement.



***The day before the resident was asphyxiated two aides found her tangled in her bedding, clothing and restraints and close to strangling herself in the bed rails.***

***The aides informed their supervisor of the problem, but despite this knowledge nothing was done to rectify the situation. That would amount to negligence.***

SUPREME COURT OF MICHIGAN  
July 30, 2004

### **Resident Found Tangled No Corrective Action**

The day before the resident's tragic death two aides found her lying in her bed very close to the bed rails tangled in her restraining vest, gown and bed sheets. The aides untangled her and repositioned her. They repositioned the wedges to try to keep the resident from slipping into the gap that existed between the mattress and the bed rails.

The aides would later testify in court that they informed their nursing supervisor of the situation. They specifically told the nursing supervisor that the wedges were not staying put but instead were able to slide to the side. They were concerned if better care were not taken the patient could be hurt or even fatally injure herself.

The next day the resident was found to have slipped between the bed rails and the mattress. The lower part of her body was on the floor but her neck was wedged in the gap between the bed rail and the mattress.

She was not breathing and had to be rushed to a hospital. She never recovered. Two days later she was taken off life support and allowed to expire. The family sued the facility seeking damages for wrongful death.

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