Psychiatric Patient Falls, Dies: Court Rules That Nursing Assistant Was Not Negligent.

The patient came in to the hospital through the emergency room and was admitted with diagnoses dehydration, delirium and severe depression.

At that time he was assessed and classified as a high fall risk. After showing some signs of improvement in his medical condition he was transferred to a different facility within the Veterans Administration system and placed on the psychiatric unit with the plan that at some point he would begin ECT treatments for his depression.

On the psychiatric unit further assessments by the medical and nursing staff disclosed that he was a little unsteady but was able to stand and get in his wheelchair with minimal assistance.

Nursing assistants were nevertheless assigned to help him get out of bed, use the restroom, shower, shave and dress. He was given assistance to transfer from his bed or his chair to and from his wheelchair and he was wheeled to the dining room.

On the day he fell the night-shift nursing assistant helped him with his morning personal hygiene routine and then wheeled him to the dining room for breakfast.

After breakfast he was observed by a staff member at the nursing station walking back to his room by himself pushing his wheelchair.

The patient was able to stand and get in his wheelchair by himself with minimal assistance, although the nursing assistants were still tasked to help him with personal hygiene and to wheel him around on the unit in his wheelchair.

The same a.m. before he was found on the floor in his room he was seen able to ambulate on his own pushing his wheelchair.

The nursing assistant did not start her morning rounds that morning until an hour later than she was supposed to start, but there is no proof that that affected the outcome.

There is no evidence he would have been found on the floor earlier and it is pure speculation that starting her rounds earlier would have prevented him from falling.

UNITED STATES COURT OF APPEALS
ELEVENTH CIRCUIT
January 11, 2013

The next person to see him was the day-shift nursing assistant. While making her morning rounds she found him on the floor in his room lying between his bed and his wheelchair bleeding from his left ear. She immediately called for assistance.

The patient was transferred back to the facility where he first came in to the E.R. and died there several days later from his head injuries from the fall.

The US Court of Appeals for the Eleventh Circuit (Georgia) dismissed the family's lawsuit which was based on the allegation that the day-shift nursing assistant was negligent for not starting her rounds to check on her patients until after 9:00 a.m. when she was supposed to start her rounds between 8:00 a.m. and 8:30 a.m.

The nursing and medical assessments were correct that the patient was semi-independent for ambulation. No one was required to provide constant one-on-one supervision, the Court said.

It could only be estimated that the patient fell some time between 7:30 a.m. when he was last seen ambulating independently and shortly after 9:00 a.m. when he was found on the floor.

It did not stand to reason, according to the Court, that the nursing assistant starting her rounds earlier would have made any difference in the outcome by preventing him from falling or causing him to be found sooner.

That would only be speculation and was not a sufficient basis to impose legal liability on the facility for the unfortunate turn of events. **Sanders v. US, 2013 WL 135575 (11th Cir., January 11, 2013).**

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