Accidental Strangulation: Bed Rails Seen As A Restraint, Nursing Home Should Have Considered Less Restrictive Alternatives.

The resident was admitted to a nursing home following a massive stroke that paralyzed her on her right side.

She was at the nursing home two months before her tragic death. During that time her cognitive abilities progressed to the point she could communicate in whispered tones.

She was still unable to swallow, had a feeding tube and was incontinent of bowel and bladder when she died.

She was completely unable to move her right arm and leg. However, apparently with her left arm and leg she was able to "wiggle" from side to side in bed. No one had ever actually seen her do this.

She apparently could also hold on to a fixed object such as the side rail of her bed with her left arm and pull herself over to one side. The nurses, nurses aides and her physician had never actually seen her do this either.

Resident Had Moved To Side Of Bed

Regardless of exactly how she was getting there, staff had on previous occasions found her at the extreme left side of her bed with her body caught between the side of the mattress and the bed rail.

Accidental Strangulation

At about midnight a CNA saw the resident resting on her left side with her eyes closed and pillows propped under her to support her at a 35 to 40 degree angle with her head raised so she would not aspirate fluids from the feeding tube in her stomach. The aide had come to the room to try to calm down her roommate.

An hour later she was found dead with her head wedged between the side of the mattress and the bed rail. The mattress was pushed up against the bed rail on the opposite side of the bed.

Nursing Home Ruled Guilty of Negligence

The Court of Appeals of North Carolina upheld the jury's finding of negligence and award of more than $1,000,000 as damages to the family.

For this resident, a stroke victim, the bed rails should have been seen as a form of restraint and their use evaluated under the legal criteria for use of restraints.

State and Federal statutes and regulations require that less restrictive alternatives be considered and ruled out before a particular form of restraint is used.

The nursing home's own policy manual on use of restraints was included in the evidence against the nursing home in court.

The nursing staff should have performed an assessment and documented the assessment on the nursing home's restraint assessment form.

The nursing staff should have documented the effectiveness of less restrictive measures than the restraint that was to be used.

The restraint selected should have been reviewed by the nursing home's Restraint Alternative Team/ Committee.

It is evidence of civil negligence for a healthcare provider not to follow its own internal policies.

COURT OF APPEALS OF
NORTH CAROLINA
July 2, 2002

Bed Rails Seen As Physical Restraint
No Restraint Assessment
No Consideration of Less Restrictive Alternatives

The family had expert witness testimony from a nurse whom the court accepted as an expert on the legal standard of care for nursing homes.

The family's expert faulted the nursing staff for failing to see the bed rails as a form of physical restraint and for failing to follow generally accepted standards and the nursing home's own internal policies for use of physical restraints.

Death Was Foreseeable / Negligence

Apart from the restraint-assessment issue, the jury also found the nursing home negligent because the way the resident died was foreseeable.

In a civil jury trial the court can allow either side to present evidence and make arguments to the jury on more than one theory for their case.

She had got herself caught before and that hazard should have been anticipated and dealt with. According to the court, padded side rails, half side rails or a bed alarm should have been considered.

The court pointed out this resident on several occasions prior to her death had somehow slid over to the side of her bed and become caught between the edge of the mattress and the bed rail.

The family's expert witness also testified it was foreseeable in general terms with patients like this for them to get themselves caught between the side of the mattress and the bed rail.

Family Had Complained When Bed Rails Were Down

The jury apparently completely disregarded testimony that the family themselves had on numerous occasions complained to the nursing staff that the bed rails were not raised, being concerned about her falling out of bed. **Estate of Hendrickson v. Genesis Health Ventures, Inc., __ S.E. 2d __, 2002 WL 1462267 (N.C. App., July 2, 2002).**