When It Comes To Patient Safety, Don't Overlook The Basics

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Patient safety is a never-ending legal obligation for you, regardless of your role in the delivery of patient care. One aspect of patient safety is to ensure, insofar as possible, protecting a patient from falling. In the following case[1], a very obvious protection from a fall was somehow disregarded.

Mrs. Petralia was 88 years old and was diagnosed with dementia. She was admitted to a nursing home in 2008. Approximately eight months later, she fell out of her bed at the nursing home, sustained an acute right distal fracture, and required an open reduction internal fixation surgery[1]. This latest fall from her bed was her 8th since she had been admitted as a resident at the home.

Mrs. Petralia sued the facility to recover damages from her personal injuries. She alleged her injuries were due to the facility's negligence and professional malpractice.

Unfortunately, Mrs. Petralia died after she filed her case. Her son, who was the administrator of her estate, was substituted as the plaintiff in the suit filed by his late mother.

Her son's accusations against the facility were that the facility was negligent and "departed from accepted nursing home practices by failing to order and enforce proper fall precautions, to have bed rails up at the time of her latest fall, [failing] to restrain her, and [failing] to timely and properly respond to a bed alarm".

After the completion of discovery in the case, the nursing home filed a Motion for Summary Judgment based on its expert's opinion that the home did not breach its standard of care. The expert based his opinion on the fact that Mrs. Petralia's plan of care included fall prevention interventions, that restraint of the resident was "unwarranted", and the nursing staff responded to the resident's bed alarm in a timely manner.

However, the son's expert opined that the nursing home did not meet its standard of care because, at the time of her fall, the bed rails were down, not up. Additionally, he testified that the home had failed to order alternative fall prevention measures. And, he added that the nursing staff had not adequately responded to the bed alarm.[1]

The lower court granted the home's Motion for Summary Judgment and the son appealed that decision.

The appellate court reversed the decision of the trial court, holding that the son had raised a triable

issue of fact through his expert's opinion and the case should go to trial. Evidence was produced during the discovery phase that the care plan for Mrs. Petralia required that the bed rails were to be raised "at all times" when she was in bed.

Evidence was also produced by the expert that the bed rails were down when the fall occurred. The failure to raise the bed rails was the proximate cause of the fall, he stated. He also testified that bed rails serve many purposes other than just to prevent falls. Raised bed rails also remind the resident not to get out of bed by himself or herself, are a source of emotional comfort, and provide feelings of security for the patient.

The court also held that when a nursing home does not raise bed rails as ordered and/or fails to follow their own policies governing raised bed rails, the home can be held liable.

The failure of the home and the nursing staff to adhere to a fundamental, basic safety measure to prevent a resident from falling out of bed is astounding. The utilization of bed rails should be an automatic aspect of a resident's care, especially for a patient with compromised mental capacity.

Furthermore, Mrs. Petralia had fallen out of bed 7 times before her most recent fall. The nursing staff knew of her risk of falling out of bed. Yet, for whatever reason, this knowledge did not move them to protect her from this known risk of harm.

Whether you practice in a nursing home or in another health care setting, this case has implications for you. They include:

- Patient safety is an ever-present legal obligation;
- Always assess, on an on-going basis, a patient's safety risks and make those risks known to nursing staff, the patient's physician or advanced practice registered nurse, and incorporate preventions in the patient's written plan of care;
- If nursing staff or other health team members are not adhering to the plan of care, notify your nurse manager;
- Do not ignore patient call bells; respond to them as quickly as possible;
- Bed rails are for a patient's protection and should be used as the patient's situation warrants;
- Although an order may not be written for the use of bed rails, you can initiate using them based on your nursing judgment and convey your judgment to your colleagues and to those who can implement an order, if needed;
- Know your facility's policies on the use of bed rails and follow them without fail; and
- As this case points out, if ignored, basic, fundamental aspects of nursing care can result in liability.

FOOTNOTES

1. Petralia v. Glenhaven Health Care Organization, d/b/a Glengariff Health Care Center, 39 N.Y.S. 3d 515 (N.Y. App. Div., 2016).

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