Nurse Case Study: Failure to monitor high fall risk patient; failure to educate family on fall prevention

Nurse Medical Malpractice Case Study with Risk Management Strategies Presented by NSO and CNA

Summary

The insured registered nurse (RN) was working in an adult care neuro-intensive care unit (Neuro-ICU). The Neuro-ICU was located inside a progressive academic research hospital that utilized continuous video monitoring capabilities in all of the intensive/critical care units, as well as the emergency department. The hospital used the continuous video monitoring as an additional safety intervention to enhance patient safety.

The patient was a 60-year-old female who had recently suffered a cardiac arrest while dining with her family. Upon EMS arrival, she was unresponsive and without a pulse. She presented to the emergency department intubated, pupils fixed, not moving and unresponsive. A CT scan of the brain without contrast showed no evidence of acute intracranial hemorrhage or acute territorial infarction.

She was admitted to the Neuro-ICU on a ventilator. A neurological examination indicated that the patient was comatose and the hospital's hypothermia protocol was initiated. After a few days on the ventilator, a palliative medicine consult noted that a long meeting was held with the family concerning the patient's condition and prognosis. The family understood that it was unlikely that the patient would regain full mental status. However, over the next few days, her mental status appeared to improve, with the patient opening her eyes in response to her name and following simple commands. The neurology team noted that the patient suffered from an element of hypoxic-anoxic encephalopathy but was clinically improving with no abnormal movements and no myoclonus noted. The patient was extubated three weeks after the arrest. The neurologist documented in the healthcare information record that the patient was disoriented with some psychomotor slowing and left-sided weakness. Nursing documentation indicated that after being extubated, she was alert, oriented and forgetful with no seizure activity.

Twenty-four hours following her extubation, and while she was still in the Neuro-ICU, inpatient physical therapy was ordered. The purpose of the physical therapy was to assist her with regaining muscle strength and the ability to ambulate. After the physical therapy evaluation, the physical therapist (PT) documented a goal for the patient to be free from falls during hospitalization. Further PT documentation included the following:

- "Balance findings: sitting – static: Fair +; sitting – dynamic: Fair +; standing – static: Poor +; and standing –
- dynamic: Poor +. Gait pattern was noted to be unsteady with posterior loss of balance (LOB).
- Patient with difficulty negotiating walker; confused to location and unable to recognize patient's room; voice
- commands to align feet within walker; poor safety awareness; posterior LOB.
- Physician orders received for PT evaluation and treatment; patient's chart reviewed, contents noted; evaluation completed and well tolerated by patient; nursing made aware of patient's functional status; and physical therapy to follow as per plan.
- Patient educated in fall prevention interventions. Patient instructed to call for assistance prior to transfers or ambulation. Patient's functional status reviewed with healthcare team. Patient educated as to her level of fall risk, and, due to her forgetfulness, her risk for falls needs a lot of reinforcement.
- Rehabilitation potential: Good, patient is very motivated in her recovery."

Later that day, the continuous video monitoring showed that the patient's daughter and the insured RN were in the patient's room. The video depicts the RN laughing with and providing care for the patient, which included washing her

lower extremities and hair and making her comfortable while she was seated in a recliner. The video shows the RN and the patient's daughter talking with the patient in her room. The patient is seen as a Caucasian female with an average build, slow-appearing motor skills, and a somewhat deliberate sounding speech pattern.

The RN advised the patient that she was going to remove her adult brief and urinary catheter to permit time for the patient to clean her private areas. The patient advised it would only take her five minutes. The RN opened up the patient's gown to make it easier for her to access the area that was to be cleaned. The RN didn't make any other statements or provide instructions to the patient or her daughter about remaining seated in the chair while performing these tasks. When the RN left the room, the patient was seated in the recliner with her daughter seated on the opposite side of the bed.

A review of video shows the patient looking around for a washcloth with her daughter pointing to a gray bucket on top of the tray table that was on the right side of her chair. While the patient was washing, she continued to talk with her daughter. The patient began to stand while fumbling with her gown. She never stood fully upright and remained slightly bent forward. The daughter, while still seated on the opposite side of the bed, asked her mother whether she has any pain on her "butt", as she notices some redness when viewing her mother's backside. Just as the patient denies having any pain, she began to fall forward. The video shows that, after standing for 26 seconds, the patient fell forward onto her face and out of the camera's view.

The daughter can be seen walking over and asking if her mother is alright. The daughter is then heard asking for "*a little bit of help.*" Immediately, people enter the room, but they are out of camera view. The daughter is heard saying, "*I should have helped her.*" It then appears that the RN asks for assistance from another nurse. She asks the patient how she feels, and she replies "*okay.*" The RN asked how this happened and the daughter said that she just stood up and slipped. The RN then says to the patient, "*what did I say about standing up?*" to which the patient replies, "*I shouldn't have...* (something inaudible)."

The daughter states, "*yeah somebody should have been here…I should have stepped out and had a nurse in here.*" The patient was placed in the bed and assessed from head to toe. During the assessment, the patient reported neck pain. There was an obvious weakness in her right hand during bilateral hand squeezes, and she was unable to wiggle her toes. Both of these were recorded as normal before her fall.

The RN contacted the admitting neurologist and informed him of the fall and her findings of the assessment. When the neurologist arrived, he documented: *"a chevron-shaped laceration/disruption of Vermillion boarder of upper lip at two points apex of laceration towards nasal septum. Mild neck tenderness to palpation, patient is awake, alert and oriented to self, place, and year. She answers questions appropriately and follows commands, but unable to lift arms. She is hesitant to lift legs but moves them strongly and symmetrically at times. Sensation is grossly intact throughout. DTR's 1+/4 all with plantar flexion on both sides.*" A CT of the brain and neck were noted to be negative for any fractures or acute changes.

During her assessment a few hours later, the night shift nurse noted that the *"patient's pupils were equal and reactive to light, but sluggish. She is oriented to person, place, but occasionally disoriented to time and forgot where she lives. Patient complains of a stiff neck and it is clearly painful when her head is moved, states she cannot move upper extremities. She is able to shrug shoulders, only slight movements of arms noted. She is unable to have any movements of hands. She moves lower extremities but weakness noted. She is able to lift legs with some difficulty and bend at the knees."* The neurologist was updated on her change in condition, and a STAT MRI of the brain and cervical spine was ordered. The MRI suggested severe cervical stenosis with superimposed signal change within the spinal cord suggestive of a spinal cord injury/spinal cord contusion. The patient underwent a C3-C6 or C7 laminectomy with posterior fusion and instrumentation and possible iliac crest autograft harvest. Although the surgery initially was regarded as successful, the patient suffered permanent paralysis from the neck down.

Shortly after discharge from the hospital to a long-term care facility, the patient and her family filed a lawsuit against the hospital, the insured RN and several other healthcare providers, including the neurologist

Risk Control Recommendations

The following risk management recommendations, among others, may be adapted to the individual healthcare organization's environment of care:

- Ensure that nursing practice is safe, effective, efficient, equitable, timely, and patient-centered (Institute of Medicine, 2001).
- Serve as the patient's advocate in ensuring patient safety and the quality of care delivered.
- Know and comply with your facility's policies, procedures and protocols.
- Anticipate patient care problems before they arise.
- Communicate initial and ongoing findings regarding the patient's status and response to treatment in a timely and accurate manner.
- Document the practitioner notification of a change in condition/symptoms/patient concerns and document the practitioner's response and/or orders.

and neuro-surgeons. The claim against the insured RN was that due to leaving a high fall risk patient alone or alone with family in the absence of any training on fall prevention, she fell and now suffers permanent paralysis from the neck down.

Risk Management Comments

The patient (plaintiff) asserted the following damage claims: permanent paralysis from the neck down; quadriplegia; spinal cord contusion; laminectomy posterior cervical C3-C6 with fusion and instrumentation; intubation and ventilation; sacral pressure injury; need for wound VAC treatment of sacral pressure ulcer; need for indwelling catheter; need for 24/7 medical care and supervision; surgery to realign shoulders, arms and hands; sepsis; need for debridements of pressure injury; pain and suffering; and loss of enjoyment of life. The plaintiff further asserted that she had been confined to a bed.

Resolution

Defense of the claim was viewed as difficult, especially with the video of the events and the substantial documentation delineating the patient's fall status and functional status. The defense could provide expert testimony that the extent of injuries the patient suffered was made worse by the delay in diagnosing the patient, which led to a delay in surgery.

However, this would have led to finger pointing between defendants. The RN remained employed in the hospital's Neuro-ICU, and she believed that resorting to finger pointing would result in an uncomfortable working environment. A settlement on behalf of the insured RN was reached during mediation. ■

Total Incurred: Greater than $1,000,000.

(Note: Figures represent the payments made on behalf of the insured nurse and do not include any payments that may have been with respect to any co-defendants. Amounts paid on behalf of the co-defendants named in the case are not available.)

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