LIABILITY landscape

BY LINDA WILLIAMS, RN

Are your residents safe and sound when in bed?

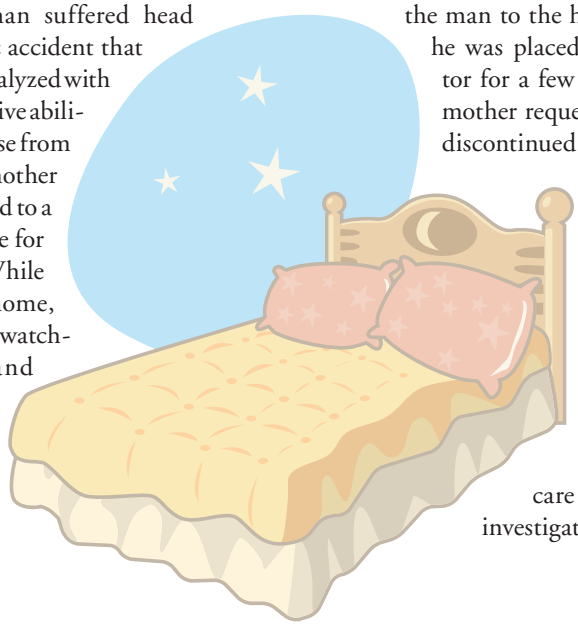
On August 23, 1995, the U.S. Food and Drug Administration (FDA) issued a Safety Alert to healthcare providers in hospital, nursing home, home health, and hospice settings concerning entrapment hazards associated with the use of bed siderails. Included in the advisement were recommendations to prevent such hazards.

While this alert helped many facilities provide a safer environment for residents, the FDA continues to receive reports of head and body entrapment incidents involving siderails each year. Recently, a nursing home in the Midwest received a deficiency tag during its annual state survey for having 54 resident beds with either loose siderails or mattresses that were too small for the bed frames. It is clear that the danger of entrapment with siderails still exists in some healthcare settings.

Please take the time to review the circumstances surrounding this recent case and make changes as appropriate at your facility.

The Situation

A 26-year-old man suffered head injuries in a tragic accident that left him mostly paralyzed with diminished cognitive abilities. After his release from the hospital, his mother had him transferred to a local nursing home for continuous care. While at the nursing home, the man enjoyed watching television and playing games with the use of assistive devices. Because of his head injuries, he became easily irritated at minor annoyances and would often have temper fits, throwing himself around in his chair and bed. Once when he was irritated, he slipped out of his recliner and onto the floor.



While troublesome, these behaviors never resulted in any physical injury, and he would always calm down afterward. For his protection, the man's mother personally selected a previously used electronic bed with half-rails for her son. The mattress appeared to be the right size for the frame, until the man lay on it, leaving a small gap between the mattress and the bedrail.

For the next two years, the man's mother was quite pleased with the care that her son received at the nursing home. One day, though, a staff member walked into the man's room and found him motionless with his head caught between the half-rail and mattress. The staff member immediately summoned help and initiated cardiopulmonary resuscitation (CPR) in an attempt to revive him.

The ambulance personnel transported the man to the hospital, where he was placed on a respirator for a few days until his mother requested that it be discontinued. The man died shortly thereafter, and his death certificate stated that the cause of his death was asphyxiation.

The state long-term care survey agency investigated the incident and cited the facility for not having provided a wider mattress for the bed, as well as padding for the half-rail, because he could have been injured numerous times earlier while thrashing about.

The man's distraught mother hired an attorney and sued the nursing home, alleging negligence contributed to her son's wrongful death. The nursing home's state survey was permitted to be entered as evidence in support of the plaintiff's allegation.

Although the small gap between the mattress and half-rail had existed for two years, nobody had seemed to notice it or become aware of the danger it imposed. Even the man's attending physician, who had viewed his bed and half-rail on numerous occasions during examinations, had not perceived the danger.

Because the mattress appeared to come with the bed, the facility's attorney tried to contact the bed's manufacturer but learned that the bed, while in good working condition, was an older model, and the manufacturer had gone out of business years prior.

The lawsuit demand was for just under a million dollars and was settled months later by the nursing home for $590,000.

Protecting Your Residents and Facility

Identifying the dangers of entrapment hazards with siderails takes a focused effort on the part of healthcare providers because it can easily be overlooked, as this tragic case demonstrated. The FDA advises that most reported entrapments within recent years occurred in one of the following ways:

- through the bars of an individual siderail;
- through the space between split siderails;
- between the siderail and mattress; or
- between the headboard or footboard, siderail, and mattress.

Elderly populations are at highest risk for entrapment, especially those with pre-existing conditions, such as confusion, restlessness, lack of muscle control, or a combination of these factors. It is important to always assess a resident's needs before using siderails on a regular basis. If the use of siderails is determined to be appropriate, beneficial, and safe for the resident, follow these FDA recommendations:

- Inspect all bed frames, siderails, and mattresses as part of a regular preventative maintenance program to identify areas of possible entrapment. Be aware that gaps can be created by movement or compression of the mattress that may be caused by the resident's weight, movement, or bed position.
- Be alert to replacement mattresses and siderails with dimensions different from those of the original equipment supplied or specified by the bed frame manufacturer. Variations in siderail design and thickness and/or density of the mattress may affect the potential for entrapment.
- Check siderails for proper installation using the manufacturer's instructions to ensure a proper fit (e.g., avoid bowing, ensure proper distance from the headboard and footboard, etc.).
- Ensure that the resident's size and/or weight are appropriate for the bed's dimensions.

Be aware that, even if the bed frame and mattress appear safe, sometimes a resident's limbs can become caught in small siderail openings, causing traumatic injuries. To minimize this danger, assess the resident, discuss options with responsible parties, and plan the resident's care accordingly. There are many types of bed bolsters, guards, and padding available through various medical supply outlets. Make sure the selected device is always secured and eliminates gaps between rails and mattress.

Proactive planning is essential in order to adequately safeguard your residents from potential dangers such as those caused by entrapment hazards described in this case. For more information about bed safety, see the FDA's Web site at **www.fda.gov/cdrh/beds**.

Finally, the Safe Medical Devices Act of 1990 (SMDA) requires healthcare facilities to report deaths, serious illnesses, and injuries associated with the use of medical devices. Healthcare workers should follow the procedures established in their facility for such mandatory reporting. ■

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