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LVH patient trapped in bed died

Hospital says the specialty bed was defective

A confused patient at Lehigh Valley Hospital-Cedar Crest who was put in a specialty bed died this year after being found trapped between the mattress and a side rail.

The hospital continued to use the same type of specialty beds for other patients for the next 13 days until hospital staff found another patient in a different Lehigh Valley Health Network facility trapped between the mattress and a side rail, according to a report by the Pennsylvania Department of Health.

The deceased patient was 88-year-old Donald Campbell of Whitehall Township, Lehigh County Coroner Scott Grim said. He ruled Campbell's death accidental.

In a statement, officials at the hospital called Campbell's death "a tragic accident." The statement also called the bed "defective," but a spokesman would not elaborate. The statement did not identify Campbell by name.

The Health Department's report, issued on June 21 but only released this month, said the specialty bed came with a warning that "serious or fatal injury can result" if a patient gets stuck in the bed. A patient who is unsettled in bed is "at risk of gradual movement and/or sliding into hazardous position of entrapment," the warning statement said.

Campbell, who was not named in the report, was admitted Dec. 9, 2010, and died Jan. 11.

According to the June 21 report, Campbell had heart surgery at another hospital and then suffered a heart attack. He recovered at a skilled nursing facility but was admitted to LVH after showing a decreased appetite and "decreased mental status." Campbell was weak and lethargic upon admission, it said.

The specialty bed, according to LVH spokesman Brian Downs, has a pressure-sensitive mattress that helps prevent pressure ulcers and skin breakdowns. He did not identify the make and model of the bed.

Records showed Campbell was in a "confused" state on Jan. 10. Staffers charted his confusion into Jan. 11. The last written observation of Campbell alive was at 2:22 p.m., the report said.

An entry from 2:38 p.m., 16 minutes later, showed that a nurse found Campbell "in bed with the right shoulder and upper body between mattress and side rail." Another employee told state investigators that Campbell's legs were "off of the right side bed and [his] right shoulder [was] wedged between the bed and side rail with the chin resting on the side rail." He was unresponsive and not breathing.

There are 2.5 million hospital and nursing home beds in use in the U.S., according to a 2010 U.S. Food and Drug Administration safety publication on bed rails. Between 1985 and January 2009, there were 803 reported incidents in which patients were "caught, trapped, entangled or strangled" in hospital beds with rails. Of those, 480 patients died and 138 were injured. Most were "frail, elderly or confused."

Downs said an attorney representing Campbell's family has requested information about the case, a step that precedes potential litigation. With the threat of a lawsuit, Downs offered little additional information beyond the prepared statement.

Common in the 1980s, lawsuits involving hospital beds have become less frequent as hospitals and other caregivers have put more safeguards in place to prevent problems, said Tom Kline, an attorney whose Philadelphia law firm, Kline & Specter, handles such cases.

Lawsuits involving staff who fail to monitor patients in the beds are still fairly common, said Miriam Barish, an attorney with Annipol Schwartz, another firm that handles the cases.

LVH continued to use the rental beds until another incident involving a patient who was found caught between the mattress and the side rail. That patient was not harmed, Downs said. LVH then took those beds out of service, he said.

LVH's patient care policies require nurses to "monitor patients frequently to guard against patient entrapment and migration," but, the report added, "There was no provision in the facility policy for the frequency of monitoring or safety measures for confused, restless or agitated patients."

In addition, an employee told investigators that Campbell's mattress was covered with a top sheet that "made it easy for the patient to slide and change position on the bed."

In response, LVH immediately had its engineering staff change its policy so it would show that rental beds were free of defects by affixing a sticker onto power cords after inspection.

Additionally, the hospital said it would provide personal training and computerized teaching to clinical staffers on ordering and using specialty beds. Further, hospital officials agreed to develop a policy that will include an assessment of a patient's mental status before ordering a specialty bed. The new policy also would address how frequently individual patients would need to be observed and whether they would need other safety precautions such as bolsters and bumpers.

The state report found other violations of protocol involving other patients who had specialty beds. In one case, a patient was put on a specialty bed without the requisite physician's order, it said. As in the Campbell case, investigators found that in five other instances, some patients went days without reviews of the plan for their specialty bed care. Such reviews are required every 24 hours, it said.

The FDA keeps records on operational problems with hospital beds. It lists 28 recalls of hospital beds since 2003. Another FDA database shows that between Jan. 1 and June 22, hundreds of consumers nationwide logged complaints about hospital beds.

The agency has long recognized the potential risks associated with some hospital beds, issuing a safety alert titled "Entrapment Hazards with Hospital Bed Side Rails" in 1995. In 1999 it created the Hospital Bed Safety Workgroup in an effort to improve bed safety.

"Although various types may be used depending on a patient's medical and functional needs, bed rails may pose increased risk to patient safety," the workgroup noted in a 2003 report.

Another Health Department inspection report revealed this year that an LVH patient, Sister Maria Angelita Quito, died after being improperly administered insulin.

LVH statement

Our sympathy goes out to the patient's family. Unfortunately this was a tragic accident that resulted from a defective specialty rental bed. The specialty bed in this instance was a bed with a pressure-sensitive mattress that was used to prevent pressure ulcers and skin breakdowns in certain patients.

Our physicians and staff commit themselves to coming to work every day to deliver the highest-quality care to our patients in the safest environment. When something

like this happens, regardless of the circumstances, it deeply disturbs all of us who have dedicated our lives to taking care of our patients.

As suggested by state regulators, we intend to further enhance our already stringent patient care and safety policies and practices by enriching the education about specialty rental beds for staff as well as the assessment of patients who are using a specialty bed.