# COURT OF APPEAL FOR BRITISH COLUMBIA

Citation: *Vancouver General Hospital v. Zheng,* 2024 BCCA 42

Date: 20240209
Docket: CA48647

Between:

**Vancouver Coastal Health Authority Operating as a Public Hospital Under the Name of Vancouver General Hospital**

Appellant
(Defendant)

And

**Ying Wei Zheng**

Respondent
(Plaintiff)

Before: The Honourable Mr. Justice Harris
The Honourable Mr. Justice Willcock
The Honourable Mr. Justice Hunter

On appeal from: An order of the Supreme Court of British Columbia, dated October 13, 2022 (*Zheng v. Vancouver General Hospital*, 2022 BCSC 1794, Vancouver Docket S186731).

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| Counsel for the Appellant: | J.G. Dives, K.C.<br>E.J.A. Stanger |
| Counsel for the Respondent: | D.O. Shane |
| Place and Date of Hearing: | Vancouver, British Columbia<br>December 11, 2023 |
| Place and Date of Judgment: | Vancouver, British Columbia<br>February 9, 2024 |

**Written Reasons by:**
The Honourable Mr. Justice Harris

**Concurred in by:**
The Honourable Mr. Justice Willcock
The Honourable Mr. Justice Hunter

***Summary:***

*The appellant hospital appealed a finding of negligence. The appellant submits that the trial judge erred in finding a breach of the standard of care on the part of a nurse who failed to assign one-to-one supervision for a patient who later fell while unsupervised, breaking his hip. Held: Appeal dismissed. It was open to the trial judge to conclude that in these particular circumstances the standard of care required the assignment of supervision and that the failure to provide it constituted a breach of that standard.*

**Reasons for Judgment of the Honourable Mr. Justice Harris:**

## I. INTRODUCTION

[1] The issue on appeal is a narrow one: namely, did the trial judge err in concluding that nursing staff breached the standard of care in failing to assign one-to-one supervision to monitor and prevent an elderly patient getting out of bed, given what they knew or ought to have known about the risk that the patient might fall and injure himself if he did so?

[2] The appellant, Vancouver General Hospital ("VGH"), says that there was no evidence that the factual circumstances existing at the material time called for the nurses to do any more than consider whether a one-to-one assignment, alongside other possible preventive measures, was required. There was, it says, no evidence that the standard of care required a one-to-one assignment. That determination, it submits, called for expert evidence based on a clinical judgment that a reasonable nurse, who knew or ought to have known the facts, would assign one-to-one supervision. That evidence, says the appellant, was missing.

## II. BACKGROUND AND TRIAL JUDGMENT

[3] The facts underlying this appeal are set out in the judgment rendered below, indexed as 2022 BCSC 1794 [RFJ]. Ying Wei Zheng fell when getting out of a bed at VGH. He fractured his hip. The trial judge found that the hospital had breached the standard of care in a number of respects in assessing and monitoring Mr. Zheng's behaviour and in taking preventive steps to mitigate the risk of his falling if he got out of his bed. The judge found that a number of the breaches of the standard of care he

identified did not cause the accident. The one breach that did cause the accident was a failure to assign one-to-one supervision of Mr. Zheng to mitigate the risk of a fall.

[4] The accident occurred at about 0700 hours on September 21, 2016. Mr. Zheng was 83 years old at the time of the accident.

[5] Mr. Zheng was brought to the VGH emergency department shortly before 0300 hours that day and was soon thereafter admitted. At that time, his primary complaint was of a low heart rate, for which he received medication. Mr. Zheng did not have a history of falls, delusions, hallucinations, blurred vision or dizziness. When he arrived at VGH, he was acting normally and was not confused, dizzy, delusional or hallucinating. He remained alert and oriented into the morning.

[6] Mr. Zheng was admitted to the Cardiac Care Unit ("CCU") at approximately 0930 hours and was assessed. The assessment included questions regarding his functional mobility, and confirmed that he had no trouble, and did not need help with getting out of bed or out of a chair, walking, getting around, climbing stairs, getting dressed, bathing/showering or toileting.

[7] A nursing assessment was completed on the plaintiff's admission to the CCU. On the admission form, Nurse Chiu recorded that the plaintiff had no cognitive issues, and no issues with his functional mobility in terms of walking and getting around. He was calm and alert. A "Falls Risk Assessment & Care Plan" form was completed for Mr. Zheng on his arrival at the CCU. The form provides for a scoring between 0 and 5 based on risk of falling. A score of 2 or more indicates a risk of falling and requires the nurse to complete a second portion of the form to assess the patient's fall risk and assign fall prevention strategies and interventions. While the judge was unable to ascertain the score on Mr. Zheng's form, it is clear that the second section of the form was not completed. The judge observed, at para. 46:

> Nurse Chiu explained that the safety measures that could be taken for a patient at risk of falling include putting a sign on the patient's door, setting a bed alarm, moving a patient closer to the nursing station if patient was persistently confused and trying to get up, and/or increased supervision.

> Similar measures are noted on the Falls Assessment form as fall prevention strategies.

[8] The judge found that: “At the least, ... these preventative measures are steps that a reasonable nurse could take to help prevent a fall” (RFJ at para. 47). The appellant accepts that these steps are ones that could be taken, but are not necessarily ones that should be taken.

[9] At about 1500 hours, Ms. Zheng, who had been by Mr. Zheng’s side throughout, told Nurse Chiu that her father was acting strangely. Nurse Chiu came into his room and stayed there for 15 minutes to reassess him. The nurse’s notes read:

> 1500. Confusion. Patient’s daughter reported patient’s confused and hallucinating at times. Reassessed. Patient’s alert and oriented times three. Aware of reason for admission. No acute issues at present. Remains in complete heart block with heart rate of 34 to 36. Systolic blood pressure 140 to 185. Denied chest pain or light-headedness. Voiding in urinal. Had large form BM in bed pan. [RFJ at para. 51.]

[10] The trial judge found that the hallucinations were not an isolated incident but something that had been coming and going since his admission to the CCU, and, at a minimum, had happened twice. He also accepted Nurse Chiu’s evidence that Mr. Zheng was at risk of “decompensating” and falling were he to get out of bed, and she wanted him to stay in bed. The judge found, as well, that on numerous occasions the nursing staff warned Mr. Zheng that he should not get out of bed as he might fall, and that Nurse Chui was one of the nurses who gave that warning. I am persuaded that the judge accepted the following as part of his analysis:

> [56] The plaintiff contends that even if he was not confused or hallucinating when assessed by Nurse Chiu at 1500 hours, the fact this had been happening “at times” was a significant piece of information, particularly, given that Nurse Chiu already considered that the plaintiff, who was over 80 years old and at an increased risk of delirium, should not get out of bed as he had a complete heart block and could decompensate and fall.

[11] The next important event in the chronology occurred at 1800 hours. The judge accepted that Ms. Zheng told the nurses at the nursing station (although Nurse Chui was not there at that time) that she needed to go home and that she

stressed her father was not acting normally and that he was restless and hallucinating. The judge found that this information should have triggered another assessment of Mr. Zheng and a potential change in his care plan, but it was not done. This finding is not contested by VGH.

[12] The judge made the following findings:

> [73] Based on the evidence considered above, I find that the reasonable conduct of a prudent and careful nurse would have been:
>
> (a) to assess the plaintiff's risk of falling upon being admitted and about every four hours thereafter;
>
> (b) to reassess the plaintiff at 1500 and 1800 hours and find that he was a fall risk given the new information communicated by Ms. Zheng; and
>
> (c) to take precautions at 1500 and 1800 hours to reduce the risk of the plaintiff falling.
>
> …
>
> [75] The plaintiff argues, and I agree that the fact that he had been noted to be confused and hallucinating in addition to his elevated risk of getting out of bed and falling was not properly considered by Nurse Chiu.
>
> [76] I find that the defendant's nursing staff did not take the preventative measures contemplated on the Falls Assessment form, or any other preventative measures, to reduce the risk of the plaintiff falling.
>
> [77] The plaintiff's circumstances that were known to Nurse Chiu by 1500 hours on September 21, 2016 should have resulted in precautions being taken. I find that at 1800 hours that day, the ongoing and risky circumstances of the plaintiff were communicated to the nursing staff at the nursing station and should have resulted in precautions being taken to prevent his fall.
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> …
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> [79] Nurse Chiu's answers in examination for discovery concede that given the facts at the time and the Falls Assessment form, the plaintiff should have been assessed as a two out five. Accordingly, under the Falls Assessment form, as of 1500 hours, the plaintiff was a fall risk requiring that a new form be filled out and interventions taken to protect him, regardless of his mental condition at the time of that assessment.
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> …
>
> [83] Nurse Murray was not asked to comment on the need for one-to-one care for the plaintiff by either counsel at trial, although this precaution was clearly in issue at the time she gave her evidence.
>
> [84] The plaintiff's known confusion, his vacillating intellectual condition, his almost complete heart block, his risk of decompensating, and risk that he

might fall if he got out of bed, were all known to Nurse Chiu, and called for preventative measures.

[85] I find that when Ms. Zheng alerted the nursing staff that she needed to return home, the plaintiff's safety, which the nursing staff agreed was their responsibility, required the institution of reasonable preventative measures. Some reasonable measures included the preventative strategies on the Falls Assessment form, namely:

(a) engaging the bed alarm;

(b) adjusting the bed rails;

(c) moving the plaintiff closer to the nursing station; and

(d) assigning one-to-one supervision.

[86] In particular, I find that the facts of the case required the assignment of one-to-one supervision, which was not instituted as needed.

[87] In the result, the nursing staff breached their standard of care by:

(a) failing to regularly reassess the plaintiff;

(b) failing to reassess the plaintiff at 1800 hours; and

(c) failing to take any measures to reduce the plaintiff's risk of falling, specifically, by not assigning one-to-one supervision.

## III. THE APPELLANT'S ARGUMENT ON APPEAL

[13] The appellant's argument on appeal is narrowly focused. It says it does not contest the judge's findings of fact. Moreover, it does not contest the judge's conclusion that the nursing staff breached the standard of care by not properly assessing the patient after 1500 hours, and not considering or implementing preventative measures such as using a bed alarm or moving Mr. Zheng closer to the nursing station. They accepted that these steps were required to mitigate the risk of a fall.

[14] The judge erred, according to the appellant, in taking the evidence of the standard of care beyond what it supported. More specifically, in so far as the Falls Risk Assessment & Care Plan form is concerned, all that is established is that certain preventative steps could be taken or considered, but not that any particular step ought to have been taken by a reasonable nurse.

[15] This appellant's argument is buttressed by noting, as the judge accepted, that Nurse Murray, the nursing expert, was not asked to comment on the need for

one-to-one care for Mr. Zheng by either counsel at trial, although this precaution was clearly at issue at the time she gave her evidence (RFJ at para. 83). Nurse Murray went only so far as to say that one-to-one supervision might be required as a possibility alongside other possibilities if—in addition to delusions, confusion or hallucinations—the patient was exhibiting certain kinds of behaviour that put them at risk. From the appellant's perspective, the type of behaviour that could call for one-to-one supervision would be if the patient was consistently trying to get out of bed. There is no evidence, submits the appellant, that Mr. Zheng had tried to get out of bed or that any effort to do so was communicated to the nursing staff by his daughter when she spoke to the nursing staff at 1800 hours. Without relevant behaviours, none of the preventive steps outlined in the Falls Risk Assessment & Care Plan form were required to be implemented. The key point is that the patient had no history of actually trying to get out of bed. Thus, there was no need to impose one-to-one supervision. The nursing staff cannot be expected to assume that the only reason that Mr. Zheng remained in bed was because his daughter was with him until 1800 hours.

[16] The appellant goes further and says that the Falls Risk Assessment & Care Plan form does not, standing alone, prescribe a standard of care for which preventive steps ought to be taken. At best, it identifies only what should be considered and what could be implemented. What a reasonable nurse ought to do in any particular case calls for nursing judgment to assess both the need for a preventive measure and the selection of an option in light of the resources available. In particular, the availability of one-to-one supervision, in the circumstances existing at the time, is a relevant factor in determining what the standard of care mandates. Yet, in this case, there was no evidence bearing on the practicalities of providing one-to-one supervision, even if, other things equal, it was a reasonable response to the fall risk posed by the patient if he got out of bed.

## IV. STANDARD OF REVIEW

[17] It is common ground that whether the standard of care has been met or breached is a finding of mixed fact and law reviewable on a standard of palpable and

overriding error: *Housen v. Nikolaisen*, 2002 SCC 33 at para. 37. The issue is, therefore, whether the judge made a palpable and overriding error in concluding that a reasonable nurse would have assigned one-to-one supervision given what was known or ought to have been known about Mr. Zheng's risk of falling.

## V. ANALYSIS

[18] I begin by considering what seems to me to be incontrovertible about the standard of care. First, this is not an issue about a judge finding a breach of the standard of care based on common sense. What the standard of care required in the circumstances requires properly admissible evidence, including expert evidence.

[19] Second, the judge had before him admissible evidence about the standard of care. This is not contested. The issue is: how far does the evidence take him? In my view, the standard of care is informed by the contents of the Falls Risk Assessment & Care Plan form. As the judge noted, that form requires the nursing staff at least to consider strategies to mitigate the risk of a patient falling depending on the circumstances of the patient. The form also identifies possible steps that should be considered and might be taken. This is not contested by the appellant. The appellant, for example, does not challenge the judge's conclusions that the standard of care was breached by failing to reassess Mr. Zheng, implement a bed alarm or move him closer to the nursing station.

[20] Furthermore, the judge had the benefit of Nurse Murray's evidence about the circumstances calling for the implementation of certain potential steps to mitigate the risk of a fall. The judge recognized that Nurse Murray was not specifically asked about whether, on these facts, one-to-one supervision should have been assigned, but, in my opinion, she gave some evidence bearing on the issue that is capable of supporting the judge's finding of a breach.

[21] Nurse Murray's evidence on this matter boiled down to recognizing that a patient's cognitive status, standing alone, is not sufficient to require taking steps to mitigate risks. This is because many patients in a hospital may be delusional or

hallucinate without being a fall risk. What more is required is behaviour that demonstrates that the patient is at risk of falling. As she said:

> A. … So it's not just the fact that a patient is confused 'cause there's lots of patients in the hospital that are confused, and it's really the behaviours associated with that confusion that would determine what -- what the needs are in terms of if they need to be restrained or have a sitter or be considered to relocate them somewhere else on the unit.

[22] As I see the matter, an inference is available on this evidence that certain steps to protect against a risk of a fall will reasonably need to be taken, depending on the facts of a particular case. In other words, depending on the nature and severity of the risk of a fall, more will be required than simply considering whether to take a particular step, rather, certain steps ought to be taken.

[23] The issue then becomes whether it was open on the evidence for the judge to conclude that one-to-one supervision ought to have been assigned, given Mr. Zheng's risk of falling. This a critical point because, in substance, the appellant says that there was no communicated risk that Mr. Zheng was trying to get out of bed or evidence that he was in fact trying to do so. This is the alleged palpable and overriding error made by the judge.

[24] I am unable to accede to this argument. In my opinion, it was open on the evidence for the judge to find that the nursing staff were anxious to ensure that Mr. Zheng did not get out of bed because he was a fall risk, that he was in fact a fall risk because he was exhibiting behaviours demonstrating that fact, and that the nursing staff knew or ought to have known that he was a fall risk because he was exhibiting the potential for risky behaviour. In these circumstances, subject to one caveat, it was open to the judge to marry his findings of fact about the risk of Mr. Zheng falling to the standard of care evidence proffered by Nurse Murray and conclude that the standard of care had been breached.

[25] As noted, the judge found as a fact that Mr. Zheng exhibited an elevated risk of getting out of bed (RFJ at para. 75). In my view, this finding was open to him on the evidence. Ms. Zheng testified, in evidence clearly accepted by the judge, that her

father's symptoms were worsening and "it's like they got worse and worse to a point that he is like really restless and he's ready to jump out of bed any time" [emphasis added]. I note that, in oral submissions, the appellant did not take issue with this finding. Its point is slightly different, turning on the propositions: first, that Mr. Zheng had not been attempting repeatedly to get out of bed and had remained in bed until he got out and fell; and, second, that the risk of him getting out of bed had not been communicated to the nursing staff. On the former contention, it seems to me to be beside the point that Mr. Zheng had remained in bed while his daughter was by his side. What matters is whether the staff knew or ought to have known that he was at risk of trying to get out of bed and falling if he did so.

[26] I begin by noting some critical findings of fact. The judge found that Mr. Zheng's "elevated risk of getting out of bed" had been communicated to Nurse Chui at around 1500 hours. He also found that, at 1800 hours that day, the ongoing and risky circumstances of the plaintiff were communicated to the nursing staff at the nursing station. I take this to describe not merely Mr. Zheng's confusion and hallucinations, but also an elevated risk that he might or would try to get out of bed. In my view, there is support for this finding in the evidence of Ms. Zheng. In response to being asked about communicating her concerns to the nursing staff at 1800 hours, Ms. Zheng explained that she brought her concerns to the nursing staff and, at another point in her evidence, says she told the nursing staff that her father was restless.

[27] The judge also accepted that Nurse Chui had, on numerous occasions, warned Mr. Zheng not to get out of bed and accepted that, given his underlying medical condition, he was a fall risk if he were to do so.

[28] As I read the judgment, the trial judge found that the nursing staff knew that Mr. Zheng was at an elevated risk of getting out of bed and that if he were to do so he was at a risk of falling. This is so, not just for Nurse Chui, but the staff to whom Ms. Zheng expressed her concerns. I think those findings were open to the judge on the evidence. To the extent the judge may have inferred that communicating

"restlessness" encompassed a risk of getting out of bed, that inference was open to him. It was also open to the judge to infer that when Ms. Zheng communicated her concerns to the nursing staff, those concerns included that Mr. Zheng was ready to jump out of bed at any time.

[29] In short, it seems to me that it was open to the judge on the evidence to find that the standard of care required more than a mere consideration of potential steps to mitigate the risk of a fall. Given the nature of the risk that Mr. Zheng would try to get out of bed, and the risk that he would fall if he did so, it was incumbent on a reasonable nurse to take reasonable steps to prevent him from getting out of bed. It was open to the judge to conclude that certain potential steps would not be effective to prevent a fall, as he concluded in his causation analysis. It was, in my opinion, open to the judge to conclude that the reasonable step to take in these particular circumstances was to assign one-to-one supervision. This conclusion followed from marrying the more general evidence provided by Nurse Murray to the particular facts the nursing staff knew or ought to have known.

[30] This leaves one last submission advanced by the appellant. It says that what Mr. Zheng had the burden to establish was not only that one-to-one supervision was reasonably required, but that it could be provided given the resources available and be in place before a fall occurs.

[31] It is clear that the judge took the view that one-to-one supervision ought to have been in place before Mr. Zheng fell. This finding, it seems to me, has to be assessed once again on a standard of palpable and overriding error. It is also clear that the judge had no evidence that directly addressed whether one-to-one supervision could have been provided at that time. The evidence, such as it was, was vague. Nurse Chui gave evidence of what measures could be taken depending on the circumstances, and what measures she would consider taking, including getting extra staff to provide one-to-one monitoring. Significantly, she did not testify that the staff needed for one-to-one monitoring were not available either generally or on that specific occasion. She also gave some evidence about when she would

assign one-to-one supervision. Again, there is no indication that one-to-one supervision would not be provided, if she assigned it. In my view, there was an evidentiary basis capable of supporting the judge's finding that if, all other things equal, one-to-one supervision was reasonably required, then it would be provided. I do not think on the evidence the appellant has established that the judge made a palpable and overriding error in reaching this conclusion.

[32] It is important to emphasize that this conclusion does not depend on treating Nurse Chui's evidence as establishing a standard of care, or turn on her evidence about what she would do in a particular set of circumstances. Her evidence was somewhat unclear about what behaviours a patient would need to exhibit before she would take a particular course of action. All that matters here is that her evidence is capable of supporting a conclusion that, if she decided it were necessary, she could assign one-to-one supervision. Accordingly, it was open to the judge to conclude that, if the nursing staff ought to have concluded that one-to-one supervision was required in these particular circumstances, such an assignment could be made.

[33] It is perhaps worth emphasizing that the conclusion that one-to-one supervision was available, if assigned, is a finding turning on whether it was open to the judge so to conclude when assessed against a palpable and overriding standard or review. This result does not support a conclusion that the standard of care will be breached whenever one-to-one supervision could or should be considered as an option, but not assigned. Evidence of the availability of one-to-one supervision is clearly relevant to determining a breach of the standard of care. One would expect evidence bearing directly on that issue to be led, if it is material and probative to determining whether the standard of care is breached in other cases.

## VI. CONCLUSION

[34] It follows that in the absence of demonstrated palpable and overriding error, I would dismiss the appeal.

"The Honourable Mr. Justice Harris"

I agree:

"The Honourable Mr. Justice Willcock"

I agree:

"The Honourable Mr. Justice Hunter"