

## 學習式判解評析

**【醫療民事法】護理師巡房案：  
護病比一比二十八，  
如何每小時巡房？**

Case about Ward Rounding of the Nurse  
How Could a Nurse Round for Each Hour  
Insofar As 1 Nurse to 28 Patients

邱慧洳 Hui-Ju Chiu \*

**摘要**

精神病患於病房內出現怪異動作，發生姿位性窒息而不治死亡，法院認為此乃護理人員未履行每小時巡房與觀看監視器畫面之義務而未發現該病患之異樣所致，然事發當下該精神科病房之護病比為一比二十八，該名護理人員尚忙於其他病患之核對藥物事宜，如何善盡每小時巡房之義務，不無疑問；醫療機構是否違反配置充足護理人員人力之組織義務，致該護理人員分身乏術而疏於履行巡房義務，值得探究。法院僅著重護理人員個人過失責任之探究，忽略於審

\*臺北護理健康大學通識教育中心教授（Professor, General Education Center, Taipei University of Nursing and Health Sciences）

關鍵詞：行為義務（obligation of action）、注意義務（duty of care）、組織責任（organizational obligation）、醫療法第82條規定（Paragraph 82 Medical Care Act）、護理人員（nursing staff）

DOI：10.53106/241553062023050079005

酌醫療機構之組織義務與組織責任，未使醫療機構獨立負侵權責任，且於論斷護理人員之過失責任上，未依善良管理人注意義務標準加以衡量，其見解非無探究之餘地，本文擬參照實務與學說見解評析之。

A psychiatric patient died of postural asphyxia after strange movements in a hospital room. The court found that the patient's death was caused by the nursing staff's failure to perform hourly rounds of the ward and to watch the monitor and not detect the patient's abnormalities. However, it was one nurse to 28 patients in the psychiatric ward at the time of the incident, and the nursing staff was busy checking medications for other patients, so it is questionable how they could have fulfilled their obligation to make hourly rounds. It is worth to investigate whether the medical institution violated its organizational obligation to allocate sufficient nursing staff manpower, causing the nursing staff to be distracted and negligent in fulfilling the duty to make rounds. The court focused on the nursing staff's personal liability for negligence but neglected to consider the medical institution's organizational obligations and responsibilities, which did not make the medical institution independently liable for infringement. Additionally, the court failed to assess the liability of the nursing staff according to the standard of the duty of care of a prudent person. In this essay would it be analyzed with reference to practical and theoretical opinions.

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## 壹、案件概述

### 一、案件事實

精神病患A因阿茲海默症及躁鬱症，入住甲醫院精神科慢性病房，於2016年9月14日上午0時14分，其將上半身垂掛於病床護欄欄杆外，於1時57分，已無任何掙扎動作，於3時36分，同病房之室友發現上情，通知護理人員B，然A經急救後，仍於4時26分因姿位性窒息而不治死亡。

#### （一）病家主張

甲醫院之「精神科病房工作手冊」第四部分之「精神科病房組織系統」之第7項「大夜班（0時至8時）工作職責」規定：「視情況而定時隨時巡房，以了解病患病況，最少每小時須查1次並留下記錄，特殊情況得隨時」（下稱系爭規定）。B為2016年9月14日大夜班（0時至8時）之負責護理人員，其未依系爭規定巡房及看護A之睡眠狀況，未確實監看值班臺之監視器畫面，未注意A於上午0時將雙腳伸出病床護欄欄杆，於0時14分將上半身垂掛於病床護欄欄杆外，於1時57分已無任何掙扎動作。又甲醫院事發當日大夜班僅配置一名護理人員照顧二十八床病患，護理人員人力顯有不足，違反醫療常規。病家主張上開B之過失行為與A之死亡結果有相當因果關係，請求B與甲醫院依侵權行為法律關係連帶賠償。

#### （二）護理人員B與甲醫院主張

##### 1. 過失

B主張當日大夜班僅有其一人照護二十八床病患，交班時A身體並無異常，基於人力不足因素，實難兼顧周到，僅能透過監視器畫面輔助之，然並未發現A之異樣。甲醫院之巡房規定，是甲醫院與B間僱傭契約內部之管理，該內部管理之巡房