## Labor And **Delivery: Nurses Did Not Report Abnormal Monitor Tracings To The** Physician.

he patient, an insulin-dependent diabetic, went to see her ob/gyn at thirtysix weeks because she had not felt any fetal movement for two days. She was atric registered nurse advanced practitioner medical director, medical equipment supadmitted to the hospital two days later.

When the patient's ob/gyn came into the patient's room the nurse held up the monitor strip as if to signal to him there was a problem which required his immediate attention.

The nurse testified later she did not want to say anything in front of the mother that might alarm her and did not want to leave her patient to go out in the hallway to talk to the physician.

The physician did not understand what was going on, left the room and went to see his other patients.

COURT OF APPEAL OF LOUISIANA December 22, 2009

For more than an hour a number of different nurses caring for the mother saw problems with the monitor tracings, but the into her patient's background, it was al- time the resident's head got caught in the physician was never notified what was leged, she would have realized that medigoing on.

The start of the cesarean was delayed several hours and the infant was delivered with brain damage and cerebral palsy.

The Court of Appeal of Louisiana approved a jury verdict in favor of the infant medication compliance and to close watch model hospital bed known in the industry and family, apportioned 80% against the for the onset of psychotic symptoms point- to have been recalled several years earlier hospital for nursing negligence and 20% ing against the patient's obstetrician for medi-Johnson v. Morehouse cal malpractice. Gen. Hosp., \_\_ So. 3d \_\_, 2009 WL 4912390 (La. App., December 22, 2009).

## **Medication Noncompliance: Psychiatric Nurse** Practitioner's **Negligence Leads To Attack On Clinic Worker.**

clinic for management of her antipsychotic medication.

doused an H&R Block tax preparer with then attacked a police officer.

The nurse practitioner lowered her hazard. medication dosage after the patient complained it made her feel drowsy in the morning.

Then the patient went off her medication entirely and accosted, slashed and stabbed an employee at another community clinic where she was scheduled for a dental appointment, apparently thinking she was a woman who was stalking her.

The victim's lawsuit filed in the Superior Court, King County, Washington resulted in a \$5.5 million settlement from the state agency which employed the nurse practitioner.

## **Nurse Practitioner Failed to Investigate**

Her Patient's History of Violence

The nurse practitioner never looked into the reason her patient was committed to the state hospital in the first place.

If the nurse practitioner had looked of violence to other persons.

Concern over her patient's potential for violence should have led, in turn, to use cal supply company filled the order speof depot medication injection to insure cifically for this resident with a make and toward re-institutionalization grounds of danger to others. <u>Dowe v. Com-</u> turer was responsible for the fact it was munity Psychiatric, 2009 WL 5715461 (Sup. Ct. King Co., Washington, September 21, 2009).

## **Bed Rail Entrapment:** Settlement Paid For Resident's Death.

he settlement of the case filed in the Superior Court, Wake County, North The patient was discharged from the Carolina was reported on condition that the state hospital into the care of a psychi- names of the patient, nursing facility, at an outpatient community mental health plier and manufacturer remain confidential.

The settlement was \$1,635,000 for the family of a sixty-one year-old Alzheimer's The patient had been sent to the state patient who died from positional asphyxia hospital for involuntary treatment after she after his head was caught in the bed rails of an obsolete hospital bed model which had gasoline and attempted to light him on fire, been recalled by the manufacturer several years earlier for the very same entrapment

> This was an older-style hospital bed which had been recalled by the manufacturer because the bed rails presented an entrapment hazard.

> The first time the resident's head was caught in the bed rails staff did noth-The second time he ing. was strangled and died.

SUPERIOR COURT WAKE COUNTY, NORTH CAROLINA September 1, 2009

The facility staff did nothing the first bed rails. The resident was not injured but cation non-compliance posed a serious risk the incident did put staff on notice of a potentially fatal entrapment hazard.

> It was not clear how or why the medion and whether the supplier or the manufacstill in stock. Confidential v. Confidential, 2009 WL 5766598 (Sup. Ct. Wake Co., North Carolina, September 1, 2009).