LEGAL EAGLE EYE NEWSLETTER

April 2010 — *For the Nursing Profession* — Volume 18 Number 4

Do Not Resuscitate: Nurse Faulted For Delay While Looking For Patient's Code Paperwork.

The patient was in the skilled nursing facility recovering from surgical repair of her broken hip.

The patient began to cough, choke and gasp for breath while her son was visiting with her in her room. The son called for a nurse.

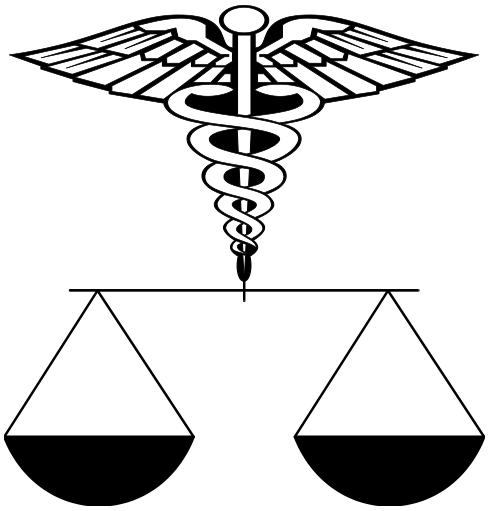
A nurse came to the room and began trying to rouse the patient by shouting and shaking her. The patient kept gasping for breath and had no palpable jugular pulse.

The nurse asked the son whether or not his mother was a DNR patient. The son replied he had no idea what the term "DNR" meant. The nurse began looking around for the patient's DNR paperwork.

Almost eight minutes after the patient first started choking, when the nurse was satisfied there was no DNR order in the patient's chart, CPR was started and paramedics were finally called.

Paramedics transported the patient to a nearby hospital where a neurological consultation led to a diagnosis of brain death. The family consented at this point to withdrawal of life support and the patient soon expired.

The son, as personal representative of his mother's probate estate, sued the nursing home on behalf of the family for the negligence of the nurse.



The patient's family's expert's testimony correctly stated the standard of care.

There was no excuse for an eight-minute delay in starting CPR while the patient's nurse tried to locate the patient's DNR paperwork.

If it is not known that the patient is not to be resuscitated, CPR and a full code response must begin at once.

COURT OF APPEALS OF TEXAS
February 24, 2010

The Court of Appeals of Texas ruled that the patient's family's expert's opinions were right on the mark. As in many states, in Texas a qualified expert's report must be filed with the court along with any civil lawsuit alleging negligence by a healthcare provider.

When a patient goes into respiratory arrest, and it is not known that the patient is in fact a DNR patient, the legal standard of care calls for the patient's nurse or other care-giving personnel to start CPR and call a code.

CPR is to start immediately. Standard response time by a code team in a hospital setting is three minutes or less.

After CPR has been started, calling a code in a nursing home setting would mean phoning 911 for emergency medical services.

No delay in responding to a patient in respiratory arrest is appropriate while caregivers take the time to look for the patient's code-status paperwork, the family's medical expert went on to say.

Prolonged lack of air in the patient's lungs due to her obstructed airway, brain damage and the patient's ultimate death were squarely the result of the inexcusable delay before taking action while the nurse was looking for the DNR paperwork. **IHS Acquisition v. Crowson, __ S.W.3d __, 2010 WL 636964 (Tex. App., February 24, 2010).**

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E.R.: Nurses Did Not Relay Patient's Complaints To Physician, Faulted For Patient's Death From Heart Attack.

The forty-six year-old female patient came to the E.R. with complaints of chest pain and chest tightness.

The E.R. nurses got two EKG's. One was normal and one seemed to show a septal infarct. No labs were obtained for cardiac enzymes.

The physician diagnosed high blood pressure, ordered one dosage of oral captopril 25 mg and an albuterol treatment and discharged her home.

The next a.m., nine hours after discharge, the patient had a myocardial infarction at home. She was rushed to another hospital where she was dead on arrival.

The E.R. nurses never communicated to the E.R. physician that the patient's chief complaints on arrival were chest pain and chest tightness.

DISTRICT COURT
JEFFERSON COUNTY, TEXAS
January 21, 2010

The jury in the District Court, Jefferson County, Texas awarded more than $1 million to the family. The verdict was apportioned 80% against the hospital and 20% against the E.R. physician.

The E.R. physician, unlike the E.R. nurses, was not an employee of the hospital but was associated with a medical practice group that was a separate corporation.

The E.R. physician's insurer settled with the family before trial for an undisclosed sum. The fact that a settlement had been paid, although not the amount of the settlement, was blurted out improperly to the jury by one of the hospital's expert witnesses. The judge declined to order a mistrial as it did not seem to have affected the ultimate outcome. **Estate of Meaux v. Christus Health, 2010 WL 751971 (Dist. Ct. Jefferson Co., Texas, January 21, 2010).**

E.R.: Nurses Did Not Assess Full Seriousness Of Patient's Injury.

A twenty-two year-old walked into the E.R. under her own power and asked to been seen. She was driven to the hospital after her cousin shot her in the right temple with a pellet from an air rifle.

Believing it was only a superficial wound from a BB gun, E.R. personnel were very slow to respond as the patient's neurological status deteriorated to the point she became stuporous. Two hours after coming in she had to be intubated. Then it took almost two more hours to get a CT scan that confirmed a pellet in the brain and another two hours to get an air ambulance to move her to a major trauma center.

Because a victim of a gunshot wound to the head generally does not walk into the E.R. and ask to be seen, the E.R. nurse triaged the patient as urgent but not emergent

Nevertheless, a pellet from an air rifle, just like a bullet from a firearm, can penetrate the skull. Penetration of a projectile into the skull, as in this case, can lead to swelling, brainstem herniation and brain death.

SUPERIOR COURT
LOS ANGELES COUNTY, CALIFORNIA
February 11, 2010

The jury in the Superior Court, Los Angeles County, California awarded more than $12 million for patient's future care. She is now in a persistent vegetative state.

The jury reportedly heard testimony that when the police served a search warrant on the hospital risk manager for the E.R. security tapes, the tapes, which would have shown how long the patient was sitting there with little being done for her, had already been erased. **Ramirez v. AHMC Healthcare, 2010 WL 659114 (Sup. Ct. Los Angeles Co., California, February 11, 2010).**

Labor & Delivery: Nurse Tried To Ambulate Patient Too Soon After Epidural, Liable For Patient's Fall.

The patient was resting in a post-delivery room shortly after the birth of her third child, a normal healthy baby girl.

According to the patient, her nurse told her she needed her to get out of bed and go into the bathroom and clean herself up before the end of the nurse's work shift.

The patient testified she told the nurse she could not feel her legs, that is, her epidural had not worn off yet. The nurse nevertheless moved the patient to the side of the bed, drooped her legs over the side of the bed and tried to help her stand up.

The patient fell right to the floor and landed on her hip.

The patient's nurse put a note in the chart after the fact that the patient was only pretending to be injured so that she could stay in the hospital an extra day.

SUPERIOR COURT
KING COUNTY, WASHINGTON
November 20, 2009

The jury in the Superior Court, King County, Washington found the nurse 60% at fault and the patient 40% at fault.

It was reportedly not clear that it happened as the patient said. The nurse testified she never actually told her patient to try to stand but was only trying to assess her ability to stand when the patient herself decided to stand up and lost her balance and she assisted her to the floor.

However, the physician had written an order for strict bed rest until the epidural had worn off. Thus the jury was able to fault the nurse for getting her patient out of bed prematurely. The jury also reportedly was suspicious that the nurse did not chart the incident right away and then wrote a post-dated note after the fact. **Howe v. King County, 2009 WL 5945486 (Sup. Ct. King Co., Washington, November 20, 2009).**

Alzheimer's: No Chair Alarm, No Soft Restraint, Facility Settles For Broken Hip.

The seventy year-old Alzheimer's patient fell three times in his first three days in the nursing home.

The third fall resulted in a broken hip and surgery in the hospital.

The nursing home's insurer agreed to pay an $80,000 settlement. If the lawsuit which was filed in the Supreme Court, Suffolk County, New York had gone to trial the family's lawyers were prepared to argue several bases for liability.

The patient's diagnosis of Alzheimer's dementia made him a fall risk. Apparently no fall precautions were started when he first came in.

Regardless of his diagnosis, after falling twice in his first two days facility staff should have known he was high-risk.

They should have been using chair and bed alarms to alert staff that the patient was up and trying to ambulate.

The patient, it was alleged, was a good candidate for a soft restraint to keep him safely seated in his chair or safely lying in his bed. **Lopez v. Little Flower Rehab & Nursing, 2009 WL 5874631 (Sup. Ct. Suffolk Co., New York, September 1, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

Published monthly, twelve times per year.
Mailed First Class Mail at Seattle, WA.

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Post-Operative Nursing Care: Nurses Failed To Take Action.

The patient, herself a nurse, had just had a complicated anterior-approach lumbar spinal fusion. A spinal specialist accessed the spine in her lower back through an opening through her abdomen.

In the post anesthesia recovery unit that afternoon the patient's blood pressure became unstable and she had no pulse in her lower leg.

PACU Nurses Charted Their Findings Took No Further Action

The post-anesthesia nurses charted their findings but did not report to the surgeon, to the chief of surgery who had participated in the case or to anyone else.

The next a.m. when the surgeon came in and learned about the patient's condition he got a CT which confirmed the patient was bleeding internally and had an arterial blockage in her lower leg. The patient was airlifted to another facility for surgery which stopped the internal bleeding, but the leg had to be amputated.

The patient's lawsuit filed in the Superior Court, Litchfield, Connecticut resulted in a settlement offer of $5,250,000 from the hospital which the patient accepted.

The patient's lawyers were prepared to argue the nurses should have called the physician and arranged to have the patient returned to the O.R. promptly when the loss of pulse in the lower leg was first detected. **Kelleher v. New Milford Hosp., 2009 WL 5893680 (Sup. Ct. Litchfield, Connecticut, October 5, 2009).**

PICC: Nurse Infused Milk Into Newborn's Blood Stream.

A newborn in the hospital's neonatal intensive care unit was supposed to have both a peripherally inserted central venous catheter (PICC) and an orogastric feeding tube. The baby had been born several weeks prematurely.

A nurse deposited 12 cc of human milk into the infant's bloodstream through the PICC line with a nutrient syringe.

The evidence was not clear whether the nurse incorrectly attached the nutrient syringe directly to the PICC line or attached the syringe to the orogastric tube which, in turn, was incorrectly attached to the PICC line.

Milk infusion into the baby's lungs required a lengthy stay in neonatal intensive care for 100% O_2 perfusion through a ventilator.

The lawsuit filed in the Circuit Court, Winnebago County, Illinois, faulted the nurse for incorrectly connecting the nutrient syringe to the PICC line in the first place, then for failing to monitor the patient closely during and after the infusion for possible signs of an adverse reaction.

The hospital settled for $4,000,000 paid to the family for the infant's benefit and also wrote off almost $500,000 in medical expenses for the infant's care in the hospital after the event occurred. **Ramos v. Rockford Health System, 2009 WL 6022024 (Cir. Ct. Winnebago Co., Illinois, June 25, 2009).**

Hypoglycemia: Jury Does Not Hold Nurses Responsible For Newborn's Brain Damage.

The Court of Appeals of Ohio carefully examined and was satisfied with the nursing care given by the newborn nursery nurses who cared for the infant the day of his birth and the next day in the hospital.

The Court upheld the jury's verdict that the nurses were not liable for the baby's profound irreversible brain damage after his blood glucose dropped to almost zero at home the next day.

Nurse Discharged Mother / Infant Without a Physician's Order

A nurse in the nursery made the decision to discharge the mother and baby early in the evening of the second day, forty-one hours after birth.

The jury explicitly found the nurse negligent for substandard nursing practice for discharging a patient without a verbal or written order from a physician.

At the same time, however, the jury also explicitly ruled that that error by the nurse was not a legal causative factor in the baby developing severe hypoglycemia the next day at home.

Nurses Left Gaps In Neonatal Flow Charting

The jury was also shown that the nurses could not account for several hours of care because the nursing flow sheets were left blank.

Again, the jury found that that omission, albeit negligent, did not cause the unfortunate outcome and was no reason to impose legal liability on the nurses.

The nurse on duty the first day also neglected to mention anything in her nursing progress notes about the fact the physician, suspecting jaundice, had ordered bilirubin levels from the lab.

The nurse was allowed to testify in court that jaundice, in her understanding, is common in newborns and does not necessarily mean anything is wrong and, in any case, the physician was on top of it.

Not charting the baby's jaundice was also a lapse from good nursing practice, the Court said, but like the other issues was not a causative factor in the bad outcome. **Clements v. Lima Mem. Hosp., 2010 WL 597368 (Ohio App., February 22, 2010).**

The afternoon after his birth the nurse evaluated the baby's fontanels, vital signs, skin color, lung sounds, temperature, bowel tones and feeding and voiding patterns, all of which were normal.

She also stood by and observed as the pediatrician examined the infant and found him in good health.

The doctor thought the baby was cool to the touch and took his temp, 97.6°F, so the nurse wrapped him and put him in the warmer for an hour or so until his temp rose to normal.

The nurse's progress notes mentioned expressly that the baby was breast-feeding and voided meconium stool. His weight dropped 5.2% by midnight.

The nurse did not note in her progress notes that the baby seemed jaundiced, a lapse in good practice, but the nurse was able to testify she did not always note findings that were not out of the ordinary.

The next day the pattern continued of normal assessment findings. The baby was breast or bottle feeding. Mother and baby were discharged home that evening.

COURT OF APPEALS OF OHIO
February 22, 2010

O.R.: Common Practice Is Not Always The Standard Of Care.

The surgeon had planned to resect the patient's bone tumor and reconstruct her knee all in the same procedure.

During the case, after the tumor was out but before the reconstruction began, the surgeon was told of a phone call just received from the outside vendor who sterilized instruments for the hospital that a test strip for the batch of instruments they had in the room was positive for bacterial growth forty-eight hours after sterilization.

The surgeon inserted a spacer to stabilize the knee and stopped what else he was doing. Six weeks later the reconstruction was done. The patient died from her osteosarcoma.

Her mother sued the hospital as personal representative of her daughter's probate estate over the fact her daughter had to have two surgeries instead of just one.

It may be true, as the hospital's expert says, that it is not common practice among hospitals to quarantine surgical instruments pending the outcome of bacterial culturing which, if positive, could indicate less that effective sterilization.

COURT OF APPEALS OF TENNESSEE
March 3, 2010

The case has not gone to trial. There has been no definitive ruling whether the hospital was guilty of negligence.

However, the Court of Appeals of Tennessee ruled that the hospital's expert's assertion that hospitals generally do not quarantine instruments after sterilization to await the results of biological testing does not prove the hospital was not negligent.

Common practice and reasonable care are not necessarily the same thing under the law, the Court pointed out. **Turner v. Steriltek, 2010 WL 744519 (Tenn. App., March 3, 2010).**

Nursing Malpractice: Court Allows Lawsuit To Go Forward Against Facility's Director Of Nursing.

The patient was admitted to a long-term care facility at age fifty-five with a diagnosis of multiple sclerosis.

On admission she had no skin impairment but was assessed as high risk for development of pressure sores.

She developed sixteen separate pressure lesions over the next four years, including several Stage IV decubitus ulcers, one Stage III, one Stage II and another lesion categorized as unstageable.

When one of her sacral decubitus ulcers began to bleed the patient was transferred to a hospital.

Hospital personnel documented on admission that her injuries included:

A sacral pressure ulcer so large, deep and infected that liquid stool was seeping out of her vagina;

A scalp pressure ulcer that appeared to reach down to the skull;

A left leg pressure ulcer that exposed the tendons; and

Pressure ulcers on the ears which exposed the cartilage.

In addition to the skin lesions, before transfer to the hospital from the nursing facility the patient had developed a severe urinary tract infection and a respiratory infection that was causing her to expectorate yellowish-green sputum.

The patient died in the hospital shortly after admission.

The Nursing Home Care Act allows a patient, a patient's legal guardian or a deceased patient's personal representative to sue a nursing-home licensee for injuries or death from substandard nursing care.

That does not mean that the corporate licensee which owns and operates the nursing home is the only party that can be held liable in a civil lawsuit.

The director of nursing acts as a healthcare provider in her supervisory capacity as director of nursing and can be held liable for substandard care, policies and practices at the facility. In her supervisory role the director is in essence caring for the patients herself.

APPELLATE COURT OF ILLINOIS
March 17, 2010

Family's Lawsuit Faulted Director of Nursing

Among the allegations in the family's wrongful-death lawsuit were a long list of allegations leveled at the facility's director of nursing herself, not in her capacity as a direct patient-care nurse, but in her supervisory capacity as director of nursing.

The allegations included:

Failure to hire qualified and experienced nursing staff to provide appropriate care and treatment to the patient during her stay at the facility;

Failure to ensure that the medical and nursing services provided to the patient met the applicable regulations, policies, procedures and standards for overall quality of care;

Failure to ensure the safety and welfare of the patient;

Failure to evaluate, monitor and supervise the overall quality of healthcare being provided by the attending physician, nursing staff and other medical personnel;

Failure to demonstrate personal effort to improve the overall quality of care being provided to the patient by the medical and nursing staff;

Failure to ensure that the nursing staff implemented a care plan that addressed the specific measures necessary to treat a highly complex total care resident;

Failure to ensure that the medical and nursing staff provided adequate monitoring and care to prevent the development and worsening of numerous infected decubitus ulcers;

Failure to ensure that the nursing staff appropriately assessed, monitored and consistently documented the status of the patient's skin, wounds and clinical condition during her stay;

Failure to monitor and timely obtain treatment orders for infections;

Failure to recommend that appropriate medical consultants were consulted when the patient's pressure sores continued to worsen;

Failure to ensure that the patient's skin remained free of pressure sores throughout her stay at the facility;

Failure to ensure that nursing staff notified the physician and family members of significant changes in the patient's clinical condition throughout her stay;

Failure to ensure that the nursing staff followed physicians' orders and administered medications and treatments as ordered;

Failure to ensure that the nursing staff provided appropriate care to the patient's tube stoma site in order to prevent infections;

Failure to ensure that the nursing staff kept the head of the bed at an appropriate level in order to prevent aspiration pneumonia and other respiratory problems;

Failure to ensure that the patient was properly medicated for pain;

Failure to evaluate and address the continued appropriateness of the patient's medical regime during her residency and change the plan of care as needed; and

Failure to ensure that the nursing staff followed proper nursing policy and procedures for performing gastrostomy feedings.

The Appellate Court of Illinois ruled that the allegations of the family's lawsuit contained a correct statement of a nursing facility's director of nursing's responsibilities to a patient in the facility.

DON Liable for Malpractice

Although the director of nursing herself provided only minimal direct hands-on care to this and other patients, she was still a healthcare provider in her supervisory capacity as director of nursing and could be held liable for malpractice in carrying out her supervisory responsibilities. **Childs v. Pinnacle Health, __ N.E.2d __, 2010 WL 989037 (Ill. App., March 17, 2010).**

Suicide: Jury Rules Facility Not Liable.

The ninety year-old patient was brought to the psychiatric facility by his daughter because she feared he was going to commit suicide.

During his admission assessment the patient reportedly stated that he was thinking about suicide and planned to kill himself.

The psychiatrist decided to admit him and ordered fifteen-minute checks as a suicide precaution.

On a fifteen minute check the patient was found dead with one of his socks in his mouth, an apparent suicide.

The fifteen-minute checks ordered by the patient's psychiatrist were being carried out.

It was not reasonably foreseeable that the patient would die by ingesting and suffocating himself with one of his own socks.

DISTRICT COURT
TULSA COUNTY, OKLAHOMA
January 27, 2010

The jury in the District Court, Tulsa County, Oklahoma ruled the psychiatrist and the staff at the mental health facility were not guilty of negligence.

Bad Outcome Does Not Prove Negligence

A bad outcome does not, in and of itself, equate with negligence if the patient's caregivers complied with the standard of care or if the unfortunate outcome was not reasonably foreseeable.

The jury accepted two arguments advanced by the facility in its defense.

First, fifteen minute checks were within the appropriate standard of care for this patient. Second, it was not foreseeable that the patient would use one of his own socks as the instrument of his own death. **Smith v. Laureate Psychiatric, 2010 WL 973477 (Dist. Ct. Tulsa Co., Oklahoma, January 27, 2010).**

Arbitration: Wife Signed Agreement As Patient's Agent.

The patient had to be admitted to a nursing home because of physical problems which made him unable to perform activities of daily living independently, such as bathing and dressing.

At the time of admission his mental status exam showed that he was alert and oriented despite his physical limitations.

The patient's sister arrived soon after the patient arrived via ambulance. However, the patient insisted that his wife come in to sign the admissions paperwork for him, which included an advance directive, receipt for information concerning resident's rights, Medicare and Medicaid forms and an arbitration agreement.

After the patient suffered cardiopulmonary arrest and died, possibly from choking on his food, a lawsuit was filed by the executor of his probate estate.

A mini-mental status exam was done as the patient was being admitted. The patient was found to be alert and oriented.

The patient had physical problems which made it impossible for him to hold a pen and sign his name.

The patient asked specifically for his wife to come in to sign the papers for him.

COURT OF APPEALS OF KENTUCKY
March 19, 2010

The Court of Appeals of Kentucky ruled it was not proper for the case to have been filed in civil court. The case belonged in arbitration, the Court said.

As a general rule a patient who is mentally competent must sign the arbitration agreement himself or the agreement is not valid. In this case, however, it was clear that the patient, who was mentally competent to appoint an agent, appointed his wife as his agent for the purpose of signing for him. The arbitration agreement was valid. **Laurel Creek v. Bishop, 2010 WL 985299 (Ky. App., March 19, 2010).**

Transfer: Patient Should Not Have Been Allowed To Bear Any Weight On Her Leg.

The physician's progress note indicated the eighty-one year-old patient inadvertently put weight on her left leg during a transfer, twisted it and heard a pop. The surgical internal fixation of her left femur fracture came apart and had to be redone.

The patient's chart referenced the injury only with hearsay in the physician's note to the effect an aide had said the patient was transferring off the bedside commode to her wheelchair when it happened.

The physical therapist had beforehand written a progress note that the patient had no control of her left leg during transfer maneuvers and required two-person maximum assistance.

The rationale for requiring two-person assists in all transfers was that this patient was not to bear any weight on her left leg.

She had fractured her left femur in a fall at home and had undergone open reduction and internal fixation at the hospital before being moved to the rehab facility.

COURT OF APPEALS OF TEXAS
March 18, 2010

The Court of Appeals of Texas accepted the patient's nursing expert's opinion that the patient's care at the rehab facility fell below the standard of care because the facility did not supervise its staff to ensure that the patient received competent assistance during transfers.

The Court threw out the facility's argument that a medical expert could not say definitively that undoing of the internal fixation was caused by weight bearing on the leg during a transfer. **Clear Lake Rehab v. Karber, __ S.W.3d __, 2010 WL 987758 (Tex. App., March 18, 2010).**

Blind Patient Scalded: Jury Finds Nurse Not Negligent.

Two Styrofoam cups were placed on the bed tray by the patient's nurse. One cup contained hot water for tea.

The patient, legally blind, spilled the hot water on her leg and burned the skin.

The jury in the Circuit Court, Broward County, Florida refused to fault the patient's nurse for failing to notify the patient of the location on the tray of the cup containing the hot water. **Spencer-Edwards v. FMC Hosp., 2009 WL 6047359 (Cir. Ct. Broward Co., Florida, July 1, 2009).**

Abuse: Financial Dishonesty Can Disqualify A Direct Care Giver.

A mother who had been caring for her own disabled son as an employee of a home health agency went through a criminal background check when such checks were first required by state law.

It was learned that she had been convicted of felony forgery in 1999 and felony issuance of a bad check in 2004. The state licensing agency informed the home health agency that she could no longer work in direct-contact patient care.

She filed an appeal in court. The Court of Appeals of Minnesota upheld her disqualification.

She pointed out she had been working in direct care for some time without even a hint that she was capable of physically abusing or neglecting a vulnerable person.

However, criminal convictions for two separate major incidents of financial dishonesty posed serious doubts about her fitness to work with vulnerable persons without risk of financial exploitation.

She offered nothing, such as professional mental health assessment, to show that she was remorseful or had been rehabilitated. **Acheaw v. Commissioner, 2010 WL 935490 (Minn. App., March 16, 2010).**

Neurosurgery: Patient's Status Changed, Nurse Failed To Access Chain Of Command.

The hospital had a procedure in place which allowed a patient's nurse to call a "Condition C" to obtain immediate assistance from a physician for a patient whose condition was perceived by the nurse to have become critical.

The hospital also had policies requiring a nurse to access the nursing chain of command when the nurse believed that the patient's safety and wellbeing was being compromised by the attending physician's failure to act.

The state nurse practice law requires a nurse to safeguard the nurse's patient from incompetent practice by another health care provider, specifically by notifying hospital authorities if that occurs.

If the patient's nurse did report to the neurosurgeon that her patient's left pupil had become fixed and dilated, not just that the pupils were unequal, and the neurosurgeon was not willing to come to the hospital, the nurse had to act.

The nurse had an obligation to call for assistance from another physician or her nursing supervisor.

SUPERIOR COURT OF PENNSYLVANIA
March 17, 2010

The twenty-four year-old patient was diagnosed with an aggressive brain tumor which could not be treated any other way than by surgical removal.

The patient's pupils were uneven and the patient was in considerable pain. He was admitted to the neurosurgery service, started on narcotics for pain and anti-seizure medication and scheduled for surgery at 7:30 a.m. the next morning.

During the night the patient was cared for by a relatively inexperienced nurse who had just completed her orientation period. There was no more senior nurse working with her in the neurosurgery unit on the overnight shift.

Left Pupil Fixed and Dilated

The nurse wrote a progress note at 1:00 a.m. that the patient's left pupil was fixed and dilated.

According to the Superior Court of Pennsylvania, the nurse should have recognized a fixed and dilated pupil as a significant change in the patient's neurological status indicative of increasing pressure on the brain from the mass inside the patient's skull, requiring immediate medical assessment and intervention.

The nurse testified she phoned the neurosurgeon at 1:00 a.m. and reported the fixed, dilated pupil. The neurosurgeon testified that the nurse did phone him, but, on the contrary, only to report that the pupils were not equal, which was no change from the previous afternoon.

Nothing further was done for the patient until 6:00 a.m. when both of the patient's pupils were fixed and dilated. The physicians rushed him into surgery but were unable to save his life.

During the surgery it was discovered that he did not have a glioblastoma as was thought the previous afternoon but had a rapidly growing brain abscess.

The immediate cause of death was brainstem herniation from excessive intracranial pressure.

The Superior Court upheld a $2.5 million award to the family for the night nurse's negligence. **Rettger v. UPMC, __ A.2d __, 2010 WL 937277 (Pa. App., March 17, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Whistleblower: Nurse Refused To Participate In Illegal Activities, Jury Awards Damages.

A registered nurse was hired by an agency to provide skilled nursing home-care services to homebound Medicare patients.

Soon after starting with the agency she was told to admit a certain patient as a new Medicare patient for home physical therapy, despite the fact the patient was not actually homebound.

Then the nurse was told to have the patient sign forms for Medicare reimbursement stating she had seen him in his home on five separate occasions, even though she had only seen him four times.

The nurse was also ordered to falsify the dates she had seen another patient, whom she did actually see, and to make alterations to the care plan that would prolong his eligibility.

When the nurse told her manager she would not go along with what they were doing she was abruptly converted from a salaried employee with full benefits to a *per diem* nurse with no benefits.

The nurse stayed on working *per diem* for several months, then quit altogether. One month later she was hired as a registered nurse by another home health agency in the same city.

The jury in the Circuit Court, Palm Beach County, Florida awarded the nurse $60,000 in damages and an additional $110,000 for her attorneys' fees and litigation costs.

Nurse Refused to Participate In Falsification of Medicare Documents

The jury's verdict was based on state law which protects employees from employer retaliation for refusing to participate in an employer's illegal activities, policies or practices.

It is an illegal activity, policy or practice, the jury determined, for an employer to insist that an employee falsify Medicare documentation to obtain reimbursement to which the employer is not entitled.

The jury also determined that the nurse was a victim of retaliation even though she quit her job voluntarily and was not actually fired.

It is the same as firing, by law, when the employer so drastically changes the terms and conditions of employment that the employee has no realistic option but to quit. The situation is called "constructive discharge" in legal parlance. **Admore v. Nurse Connection, Inc., 2009 WL 5874397 (Cir. Ct. Palm Beach Co., Florida, July 29, 2009).**

Language Barrier: Nurse, Physician Not Able To Take Medical History, Faulted For Infant's Death.

The uncle accompanied the one-week-old infant and his mother in the ambulance to the hospital's E.R.

Neither the mother or the uncle spoke English very well. A nurse tried to get a medical history from the uncle, but he could only communicate with broken English and gestures.

When the uncle pointed and tapped on the infant's chest the nurse asked him if the child had stopped breathing. The nurse charted that the uncle replied that he did not know.

A first-year resident physician in pediatrics also attempted to obtain a medical history but had no more success than the nurse.

The infant was simply discharged home with the family, without the nurse or physician obtaining an interpreter to get a more adequate history.

The judge awarded the parents $400,000 from the hospital for the negligence of the E.R. nurse and the resident physician.

If they had found someone to interpret for them, more likely than not they would have appreciated the seriousness of the infant's condition, would not have discharged the infant without treatment and the child would still be alive.

SUPERIOR COURT
PROVIDENCE COUNTY, RHODE ISLAND
May 1, 2009

The child stopped breathing at home four hours later and was rushed to the hospital again.

This time a diagnosis was made of an apneic event triggered by acute tracheobronchitis and bronchiolitis consistent with respiratory syncytial virus. The infant was placed on life support in pediatric intensive care, but unfortunately died four days later.

The judge in the Superior Court, Providence County, Rhode Island faulted the E.R. nurse and physician for not obtaining an adequate medical history. An interpreter was obviously required to be able go get an adequate history, which would have led to the child being kept at the hospital for treatment, not sent home. **Castillo-Monterroso v. Rhode Island Hosp., 2009 WL 5893830 (Sup. Ct. Providence Co., Rhode Island, May 1, 2009).**