LEGAL EAGLE EYE NEWSLETTER

April 2011 For the Nursing Profession Volume 19 Number 4

Colostomy Care: Nurses Delegated Care To Family Member, Patient Fell, Broke Her Hip.

The seventy-four year-old nursing home patient was on a bowel program preparing her for surgery to reverse her colostomy that had been necessary for intestinal complications following bladder-suspension surgery.

Her son came to visit in the morning. He went to the nurses station and told the nurses his mother needed to have her bag emptied. The nurses told him to take her to the restroom and do it himself.

Later that day the patient's eighty-one year-old long-time male companion who was visiting the patient in her room went to the nurses station for the same reason.

The nurses later testified they told him to go back to the room, ring the call bell and an aide or aides would come to the room and take her to the restroom and empty the bag, but they never responded to the call bell.

The companion later testified he was told to take her to the restroom himself and empty the bag himself just like the nurses had told the other family member earlier that same day.

The patient fell while she and her companion were on their way to the restroom. She broke her hip. The jury returned a verdict of $345,000 against the nursing home and the nurse staffing agency, the nurses' employer.

The nurses testified they told the family member to go back to the room, ring the call bell and an aide or aides would come to help the patient to the restroom and empty her colostomy bag.

The family member testified the nurses told him to take her to the restroom and empty the bag himself just like they told another family member earlier.

COURT OF APPEALS OF MICHIGAN
March 22, 2011

The Court of Appeals of Michigan reviewed the allegations in the lawsuit.

It was alleged in the lawsuit that the nurses aides, who worked for the nursing home, failed to take an active role carrying out the patient's bowel program to prepare her for bowel resection surgery and failed to come to the room when summoned by the family member to care for the patient.

It was alleged that the nurses, who worked for a nurse staffing agency, did not adequately assess the patient's potential fall risk, did not have a fall-care plan in place and improperly delegated nursing care to a family member who was not able to carry out the task safely and effectively.

The jury found negligence and entered a substantial verdict in favor of the patient without differentiating fault between employees of the two defendant corporations.

After the verdict the two corporations, the nursing home and the nurse staffing agency, went to bat in court against each other over the question which one was ultimately responsible for payment of the verdict.

The Court was unable at this stage to resolve the dispute between the two corporations. **Botsford Continuing Care v. Intelstaf Healthcare, __ N.W. 2d __, 2011 WL 1002872 (Mich. App., March 22, 2011).**

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Power Of Attorney: Patient Was Not Mentally Competent, Arbitration Agreement Ruled Invalid.

After the patient died the family filed suit against the nursing home for alleged abuse and neglect.

The nursing home's first line of defense to the lawsuit, before the litigation process began to assess the underlying allegations of abuse and neglect, was to insist that the family's case be taken off the county circuit court jury trial docket and heard by an outside arbitration panel, based on the arbitration agreement signed by the patient's sister at the time the patient was admitted to the nursing home.

The patient's sister was the person named as the patient's surrogate decision maker in a durable power of attorney the patient had signed while he was undergoing treatment in a hospital's geriatric psychiatric unit three weeks before he was admitted to the nursing home.

Patient Was Not Mentally Competent
Patient's Power of Attorney Not Valid
Arbitration Agreement Not Valid

The Court of Appeals of Tennessee ruled that the patient was not mentally competent at the time he signed the durable power of attorney.

The durable power of attorney being invalid, the patient's sister had no authority to sign an arbitration agreement, or for that matter, any other binding legal documents on his behalf.

The arbitration agreement itself was thus null and void and the family's lawsuit stayed on the jury-trial docket, not the result the nursing home's lawyers believed was in their client's best interests.

Patient's Medical/Psychiatric Background

The patient had Alzheimer's disease. For two years he had been running away from home and getting lost. He had been unable to use the telephone for six months. Due to the fact he did not recognize even his closest family members he sometimes became violent in their presence.

One day he held a gun to the head of his wife of thirty years and threatened to kill her. Sheriff's deputies were called and took him to the emergency room where he assaulted a deputy and ran away.

After being re-apprehended, he was admitted to the hospital involuntarily for psychiatric treatment.

A durable power of attorney is a document through which an individual may designate another person to make decisions and to enter into binding legal contracts on the individual's behalf after the individual has lost the mental capacity to do those things for himself or herself.

A durable power of attorney is valid only if the individual still had the mental capacity to enter into a binding contract when he or she signed the durable power of attorney.

If the durable power of attorney is not valid, the person named in it has no legal authority and his or her signature is not binding on the individual's behalf.

If a durable power of attorney is challenged, the legal issue is the individual's mental capacity at the moment he or she signed the durable power of attorney.

All that is required is that the person signing the durable power of attorney knew and understood the nature, extent and legal effect of the document he or she was signing.

That can be proven by the testimony of those present at the signing, family members, a notary public or professional caregivers.

COURT OF APPEALS OF TENNESSEE
March 14, 2011

Two and one half weeks into his stay in the geriatric psychiatric unit he signed a document titled "General Durable Power of Attorney" naming his sister as his surrogate decision maker. The document was notarized by a hospital employee.

At the time he signed the power of attorney he was not able to conduct a meaningful conversation. He would nevertheless often smile, nod and answer "Yes" when questions were posed to him.

He was told he was signing papers so that his sister could discuss his medicines with the doctor and make arrangements so he could go home. He reportedly said, "OK," and signed as he was told. He did not read the document and, in fact, could not read at that time.

That same day he was upset because he thought $500 had been stolen from him, but he calmed down after he was given five $1 bills, believing he had received all of his money back.

Psychiatric Evaluation

The psychiatrist testified the patient was "obviously very confused" when he was admitted to the geriatric psychiatric unit, basically catastrophically impaired in his ability just to stay organized and understand what is going on around him.

Nurses had tried on two occasions to administer mini mental status exams and documented that they were unable to do so. He was only vaguely oriented to place, date and time, was aggressive toward other patients, seemed to be hallucinating and was voicing paranoid delusions about having been kidnapped.

The nursing progress notes were admitted into evidence for the day he signed the document. He was agitated, acting out aggressively and pacing the floor in a bizarre manner early in the morning. Later that morning the nurses noted he was calm and pleasant when the family came in to have him sign the document.

He was discharged from the hospital that day against the psychiatrist's recommendation, came back to the hospital and then was transferred to the nursing home in question because of insurance coverage issues affecting hospital reimbursement. **Duke v. Kindred Healthcare, 2011 WL 864321 (Tenn. App., March 14, 2011).**

Toxic Megacolon: Settlement Faults Nursing Care.

The elderly patient reportedly spent more than a month in the nursing home and never had a bowel movement.

The patient was admitted to the nursing home with a host of medical diagnoses including chronic renal failure and progressive systemic sclerosis. Reglan and Senokot were prescribed as well as laculose prn.

The patient began to experience vomiting and had hypoactive bowel sounds, began complaining of constipation and her abdomen became distended and firm to the touch. Still she had no bowel movements.

She was finally taken to the emergency room in hypotensive shock. An x-ray showed her colon was distended with stool. During surgery it was discovered the cecum had leaked releasing massive fecal soiling into the entire abdomen. She died several weeks later from sepsis and multi-organ failure.

The family's lawsuit in the Circuit Court, Wayne County, Michigan faulted the nurses for failing to monitor the patient and failing to report obvious signs to the physician. The lawsuit settled for payments of $12,500 from the physician and $15,000 from the nursing home, most of which went to the family's attorney. **Ridgeway v. Ansari, 2010 WL 5892777 (Cir. Ct. Wayne Co, Michigan, February 4, 2010).**

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Neonatal Care: Court Faults Nurses, Not Physician, For Child's Death.

There is no conclusive evidence, extrapolating backward from the Demerol levels found in the infant's blood on autopsy, that the mother received an overdose during her labor or that the physician compounded that overdose by giving more Demerol to the baby for his circumcision.

There is convincing evidence of substandard nursing care once the newborn's condition began to deteriorate, regardless of the underlying physiologic cause for him going into crisis.

Dopamine was ordered to raise his blood pressure, but it was not started for more than an hour.

Bicarbonate was ordered when the child then went into significant acidosis, but that also was not started by the nurses until it was too late.

SUPREME COURT OF MISSISSIPPI
March 17, 2011

The newborn began to experience significant problems with respiration and his diastolic blood pressure reportedly dropped to 15.

IV fluid was ordered at 5:00 p.m. but not started until 6:00 p.m. One of the family's medical experts pointed out in his testimony that IV fluid is routinely used in the hospital and is readily available to be started as soon as it is ordered. The expert found no excuse for the delay.

A dopamine drip was ordered at 5:30 p.m. to raise the newborn's blood pressure but the drug not started by the nurses for two hours.

Around 9:45 p.m. blood gases came back showing the child was still in crisis with pH and bicarbonate levels that pointed to acidosis.

No phone call was placed to the physician for more than an hour while the child needed to be started on bicarbonate right away to reverse the acidosis, the family's expert went on to say.

The physician was not called until the child was no longer responsive to deep pain stimuli. The child had been in shock for at least one and one-half hours before orders were obtained to start epinephrine and atropine.

The Supreme Court of Mississippi ruled there were grounds for a lawsuit against the hospital for nursing negligence in the newborn's care despite a lack of conclusive evidence that the mother received an overdose of Demerol during her labor that precipitated the child's crisis in the first place. **Patterson v. Tibbs, __ So. 3d __, 2011 WL 909359 (Miss., March 17, 2011).**

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Disability Discrimination: Court Says Nurse's Wheelchair Can Be A Reasonable Accommodation.

The job description for a Fairfax County public health clinic nurse listed the physical requirements:

Work is generally sedentary. However, employee may be required to do some walking, standing, bending and carrying of young children and light-weight items up to fifteen pounds.

The job's essential functions included:

Administering of immunizations, venipuncture, planting tuberculin skin tests, collecting lab specimens, providing screening and diagnostic tests and providing pertinent health information to patients.

Nurse Released to Work After Foot/Ankle Surgery

The nurse's attempts to return to her former clinic position resulted in temporary light-duty assignments and additional medical leaves before she was terminated on the grounds that she was not able to stand and walk more that twenty minutes at a time (up from fifteen minutes which had been the standard when she was first hired) and was not able to respond appropriately to a patient emergency.

The nurse filed suit against her former employer. The US District Court for the Eastern District of Virginia refused to enter judgment in favor of the employer, a county public health department.

It was true that the nurse was not able to fulfill the essential physical demands of her public-health nurse position in the clinic during her long period of recovery from foot and ankle surgery, that is, without reasonable accommodation.

However, the evidence in the form of release-to-work letters from her treating physician pointed to the fact she probably could have fulfilled the mobility-related functions of her position with the use of a wheelchair.

The wheelchair was, in effect, requested as a reasonable accommodation when the nurse submitted her treating physician's release-to-work letters to her supervisor, an idea never seriously considered before she was terminated. **Sydnor v. Fairfax County, 2011 WL 836948 (E.D. Va., March 3, 2011).**

The fact is inescapable that the nurse's supervisor was informed by the nurse's doctor that a light-weight portable wheelchair would facilitate her ability to perform her duties in the clinical setting.

This certainly appears to be a release from a health-care professional to return to work which states that the employee has the ability to perform the essential functions of the job with reasonable accommodation.

The Americans With Disabilities Act requires an employer to make reasonable accommodation to the known physical and mental limitations of an otherwise qualified individual with a disability.

The employee has to notify the employer he or she has a disability and needs accommodation, but the employee does not have to utter any magic words.

The medical condition does not have to be formally called a disability. The employee does not have to mention the Americans With Disabilities Act or speak the words reasonable accommodation.

UNITED STATES DISTRICT COURT
VIRGINIA
March 3, 2011

Whistleblower: Court Lets Nurse's Case Go Forward.

A nurse gave antibiotics to another nurse who had a staph infection.

The nurse who gave the antibiotics believed the other nurse should not have continued working with patients. She spoke with her supervisor, hospital security and infection control about her concerns.

At the same time there was also a great deal of animosity between the two nurses that required their supervisors to call them into a meeting to discuss incidents that were going on in the workplace in front of patients.

The first nurse was terminated on grounds of violation of patient confidentiality for discussing the other nurse's staph infection with higher-ups at the hospital.

She sued for violation of the state's whistleblower protection statute.

A report is made in good faith only when there is reasonable cause to believe a dangerous condition or practice exists and the report is motivated by a genuine desire to stop the dangerous condition.

SUPREME COURT OF MAINE
March 3, 2011

Regardless of what else was going on between the two nurses, the Supreme Court of Maine ruled the fired nurse was entitled to her day in court.

A healthcare employee is protected from employer retaliation when he or she reports a deviation from applicable standards of patient care or a dangerous condition or practice that poses a risk to the safety of patients or co-workers.

The nurse will have to prove that her ongoing complaints to her supervisors about the other nurse were realistically related to patient health and safety even though the infection control nurse had assured her that the other nurse posed no such threat. **Stewart-Dore v. Webber Hosp., __ A. 3d __, 2011 WL 723545 (Me., March 3, 2011).**

Neonatal Care: Nurse's Error Leads To Death, Settlement.

One of the twins born very prematurely by emergency c-section had no respirations, heart beat or spontaneous movement at birth.

He was sent to the neonatal intensive care unit.

A nurse in the neonatal intensive care unit switched the drip line for his fluids and medications from the peripheral intravenous line in one arm to the peripherally inserted central catheter in the other arm.

In making the switch the nurse reportedly failed to close or cap the peripheral intravenous line, resulting in significant blood loss through the open line.

Two weeks later the infant began to experience bleeding in the brain and stopped breathing. A breathing tube was inserted but later discontinued, and the infant died.

The amount of the settlement was kept confidential for the parents' lawsuit filed in the District Court, Ada County, Idaho. **Philips v. Sanders, 2010 WL 5822668 (Dist. Ct. Ada Co., Idaho, November 26, 2010).**

Cardiac Monitor: Patient Dies In Holding Area.

The eighty year-old hospital patient died in the holding area outside the hospital's imaging department.

The patient's cardiac monitor had been discontinued before he was transported to the imaging department and personnel in the imaging department apparently were not informed he was waiting in the waiting area.

The family's lawsuit filed in the Court of Common Pleas, Allegheny County, Pennsylvania claimed the hospital failed to train its nurses and nursing assistants to appreciate the importance of following physicians' orders. The family obtained a $190,000 settlement. **Mutich v. Jefferson Reg. Med. Ctr., 2010 WL 5827063 (Ct. Comm. Pl. Allegheny Co., Pennsylvania, September 29, 2010).**

Sleep Apnea: Nurse's Disability Discrimination Case Dismissed.

To prove a case of disability discrimination an employee or former employee must be able to show that:

He or she has a disability as disability is defined for purposes of the Americans With Disabilities Act (ADA);

He or she can perform the essential functions of the job with or without reasonable accommodation; and

He or she was treated adversely as a result of discrimination based on the disability.

A person qualifies as disabled under the ADA if he or she:

Has a physical or mental impairment that substantially limits one or more major life activities;

Has a record of such an impairment; or

Is regarded by his or her superiors as having such an impairment.

Sleep apnea can be a disability, but in this case it is not.

The nurse had problems getting himself going on time in the morning but had no trouble doing his job as a nurse once he came on duty. He did not get help until six months after he suspected he had sleep apnea, and the CPAP machine took care of it completely.

UNITED STATES COURT OF APPEALS
THIRD CIRCUIT
March 2, 2011

The US Court of Appeals for the Third Circuit has upheld a ruling of the US District Court for the Eastern District of Pennsylvania we reported in March, 2010. The Court of Appeals had its own analysis and rationale for the result.

See *Sleep Apnea: Court Finds No Disability Discrimination,* Legal Eagle Eye Newsletter for the Nursing Profession, (18) 3, Mar. '10 p. 5.

Sleep Apnea Can Be a Disability

A 2002 Federal court case ruled that sleep apnea can be a true disability. The secretarial employee in that case had significant problems sleeping well at night and thus fell asleep frequently on the job during the day. A CPAP machine, tonsil surgery, oral meds and pure-oxygen therapy did not help her condition.

This Nurse's Condition Not As Severe

In the nurse's case, on the other hand, he never had difficulty performing his expected workload as a registered nurse and, once he started using it, his sleep problems were eliminated by the CPAP machine. His performance deficits were persistent tardiness for his 6:30 a.m. shift and fatigue which he claimed was behind a verbal lashing-out at a co-worker after which he said he would resign if he ever had to work with that same nurse again.

The nurse did not seek a medical evaluation and help for his sleep problem until six months after he first began to suspect he had sleep apnea when he woke up short of breath gasping for air.

In sum, the Court of Appeals concluded the evidence fell short of proving the existence of a disability, that is, there was not a significant impairment of a major life activity in the nurse's case.

There was also no evidence the nurse's supervisors subjectively perceived him to have a disability. A false subjective perception of a disability can be grounds for a disability discrimination case even if the employee in question does not actually have a disability.

An employee's supervisors simply being aware of an impairment does not imply they have taken that impairment into account in their dealings with the employee. **Keyes v. Catholic Charities, 2011 WL 713640 (3rd Cir., March 2, 2011).**

Labor & Delivery: Good Nursing Documentation, No Negligence Found.

The patient sued her obstetrician and the hospital alleging she was injured by the Foley catheter inserted after the physician decided not to continue her labor but instead to deliver the baby by cesarean.

The protocol was for the nurses to chart on the bedside computer the activity related to the patient's labor and delivery and postpartum care.

The objective is to record the data contemporaneously with the events, but this is not always possible given the need to care for the patient, which is the primary concern.

SUPERIOR COURT OF CONNECTICUT
February 10, 2011

The Superior Court of Connecticut pointed to a nursing progress note, *"Foley in place draining blood tinged urine prior to OR and during OR."* The blood tinged urine was further described as, *"urine in the bag with little specs of blood in it."*

The labor and delivery nurse was able to testify, based on twenty-five years experience, this is not unusual when a patient has a c-section after trying for vaginal delivery. If there was dark red blood in the Foley bag she would have charted that fact and would have notified the obstetrician.

Minutes earlier the nurse charted, "*3-way stock-cock applied, abdomen prep done, Foley inserted.*" She could not recall this c-section but testified it was her practice to examine the Foley bag carefully before, during and after every procedure.

Based on the thorough nursing documentation which revealed nothing out of the ordinary, the Court found no nursing negligence. **Bona v. Matonis, 2011 WL 783618 (Conn. Super., February 10, 2011).**

Labor & Delivery: Baby Not Sent To NICU, Judge Finds No Negligence.

The judge in the Court of Claims of New York ruled that the newborn's nursing and medical caregivers were not negligent for making the decision not to send the newborn to the neonatal intensive care unit immediately after her birth.

The infant had zero color at one and five minutes, but at thirteen minutes she was pink and remained centrally pink after being weaned from supplemental oxygen.

COURT OF CLAIMS OF NEW YORK
July 27, 2010

The infant was screaming shortly after birth but had a bluish-grayish color. A nurse immediately began blow-by oxygen which seemed to calm her. Her APGAR scores were eight at one and at five minutes of life, but she remained blue for approximately thirteen minutes.

The Court credited the hospital's obstetrics expert's testimony that it is not accepted practice to send an infant with poor color to the intensive care unit immediately, but to wait ten to fifteen minutes to see if the color improves, as was done in this case.

The regular newborn nursery would be capable of providing supplemental oxygen, monitoring the infant's oxygenation and monitoring blood glucose.

It was also not a departure from the standard of care under the circumstances for the nurses not to have called a neonatologist immediately to the birthing room.

The infant, it was eventually learned, had been born with tracheal stenosis which caused bleeding when she was finally sent to intensive care and intubated. She had to have two surgeries for that problem and surgery for a patent ductus arteriosus, none of which could be blamed on the decision not to send her to intensive care right after birth. **Karant v. State of New York, 2010 WL 5893786 (N.Y. Ct. Cl., July 27, 2010).**

Labor & Delivery: Nurse Negligent, Not Ob/Gyn, Court Says.

The New York Supreme Court, Appellate Division, agreed with the jury that the obstetrician was not negligent.

However, the Court threw out the jury's decision that the labor and delivery nurse was not negligent and ordered a new trial against her employer, the hospital.

The obstetrician was not negligent.

According to the records he came to the room within one to three minutes after the labor and delivery nurse came and got him.

NEW YORK SUPREME COURT
APPELLATE DIVISION
February 22, 2011

According to the Court, the labor and delivery nurse erred during the critical forty-five minutes right before discovery of the uterine rupture after which the child was left with cerebral palsy. The nurse:

Did not notify the ob/gyn immediately after finding that the intrauterine pressure catheter had stopped providing useful data;

Did not re-apply the catheter right away after it stopped working;

Did not notify the ob/gyn of non-reassuring decelerations in the fetal heart rate;

Did not reposition the mother on her left side;

Did not provide O_2 to the mother;

Did not provide extra fluids to the mother; and

Did not discontinue the Pitocin.

Expert opinions that the nurse was negligent came from two sources, an outside expert retained by the parents' attorney and from the patient's own ob/gyn, himself a defendant in the case and head of obstetrics and gynecology at the hospital.

The Court pointed out the patient's ob/gyn was compelled to testify against his own hospital by having to fault the labor and delivery nurse. **Reilly v. Ninia, __ N.Y.S.2d __, 2011 WL 667995 (N.Y. App., February 22, 2011).**

Dilaudid: Nurse Gave Med To Hypotensive Patient.

The twenty-four year-old patient had been diagnosed with Type I diabetes at age eleven. Since that time she had developed hypertension and had begun hemodialysis for kidney disease.

She had to be admitted to the hospital for a pulmonary embolism. A few months later she was admitted again when she complained of epigastric pain radiating to her back. IV Dilaudid was ordered prn for pain along with other medications.

During the night her blood pressure dropped to 87/49 and her blood glucose was 49. Her blood glucose rose after an infusion of IV fluid, but her blood pressure did not. Her nurse gave the prn Dilaudid.

Vital signs were reportedly never checked prior to the patient being found cold and unresponsive at 5:30 a.m. The patient had to be put on a ventilator and died two weeks later.

The patient's blood pressure was 87/49 and there were physician's orders to give a bolus of IV fluid, take a blood pressure and call the physician back.

The nurse gave prn Dilaudid for pain.

CIRCUIT COURT
OAKLAND COUNTY, MICHIGAN
March 8, 2010

The family's lawsuit filed in the Circuit Court, Oakland County, Michigan claimed that the nurse should have been aware of the effect that Dilaudid given around midnight and Zofran given at 2:30 a.m. would be expected to have on an already hypotensive patient.

Vital signs should have been closely and frequently monitored during the minutes and hours after the medications were given.

The hospital paid a settlement of $150,000. **Scott v. St. John Health Sys., 2010 WL 5814192 (Cir. Ct. Oakland Co., Michigan, March 8, 2010).**

IV Fluids: Court Does Not Allow Retrospective Review.

The flow chart from the deceased patient's dialysis session recorded the total amount of heparin given during the session.

The question in court four years later was whether the total quantity of heparin was given as an IV drip over the course of the dialysis session or whether it included a bolus of heparin given at the conclusion of the session, after which the patient died.

The US District Court for the Northern District of Ohio ruled that the affidavit from the clinic's nurse manager who took over in 2009 was only speculation as to what did or did not happen in 2007.

The nurse manager had no actual knowledge of the nurses' charting practices in effect two years before she started at the clinic.

The question could only have been resolved in the clinic's favor if the way the heparin was given had been spelled out in the original documentation by the nurse who created the documentation based on the nurse's own first-hand knowledge at the time. **Yeazel v. Baxter Healthcare, 2011 WL 711453 (N.D. Ohio, February 22, 2011).**

Wound Care: Court Says Patient Did Likely Suffer.

The Court of Appeals of Tennessee refused to dismiss a lawsuit filed by the family of a deceased eighty year-old hospice patient after maggots were discovered in the wound by a nurse when she removed the dressing from a decubitus ulcer on her foot.

The facility asked for dismissal on the grounds that the patient was not actually harmed and did not suffer pain as a result.

Testimony from a nurse established that the generally comatose patient was still capable of responding to painful stimuli and was periodically getting Lortab prn for pain. **Champion v. CLC, 2011 WL 607341 (Tenn. App., February 22, 2011).**

Fall: Fracture Not Found, Embolism Leads To Patient's Death.

The eighty-seven year-old patient's diagnoses in the hospital were dementia, malnutrition and prostate cancer.

He fell out of his chair in his hospital room. The initial x-rays of his lower leg were read as negative for fracture. Before a second set of follow-up x-rays were evaluated he was discharged back to the nursing home where he resided.

Back in the nursing home, it took a considerable time before anyone noticed the skin discoloration of his lower leg and the inversion of his right foot.

He was sent back to the hospital where he died from a pulmonary embolism the medical examiner related to delay in treatment of his right tibia fracture.

The hospital discharged the patient back to the nursing home before follow-up x-rays were read.

Back at the nursing home it took a while before anyone noticed the discoloration of his lower leg and the inversion of his foot, signs of a possible bone fracture.

SUPREME COURT
BRONX COUNTY, NEW YORK
October 29, 2010

The family's lawsuit filed in the Supreme Court, Bronx County, New York resulted in a total settlement of $325,000, half from the hospitals' and half from the nursing homes' insurance company.

The lawsuit did not allege negligence in the fact the patient fell out of the chair.

The allegations were that both facilities provided substandard physical assessment of his injuries after the fall. X-rays right after a fracture do not always show a fracture. Subsequent x-rays were obtained but never read before the patient left. At the nursing home the signs should have been noticed more promptly. **Coronado v. Montefiore Med. Ctr., 2010 WL 5893790 (Sup. Ct. Bronx Co., New York, October 29, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Hearing-Impaired Patient: Discrimination Lawsuit Settled.

A deaf individual was a patient in a rehab facility for three separate lengthy admissions for rehabilitation and physical therapy after joint-replacement surgeries.

Despite multiple requests in writing to her nurses, social worker and the administrator, she was not provided with a certified sign-language interpreter except on a couple of brief occasions and was never given a TTY for her phone so she could communicate with her family.

The facility tried to arrange for her daughter to interpret for her, which she insisted was not a suitable substitute for a certified interpreter.

She sued the facility in the US District Court for the District of New Jersey for her terror, frustration and emotional anguish from having to undergo treatment without understanding what was going on and without being able to communicate with her caregivers.

The facility reportedly paid a confidential amount and signed a consent decree that it would not treat deaf people the same way in the future.

Svenson v. Whiting Healthcare, 2010 WL 5857777 (D.N.J., November 30, 2010).

Medicare/Medicaid: New Regulations For Collection Of Civil Monetary Penalties.

On March 18, 2011 the US Centers for Medicare and Medicaid Services (CMS) announced new regulations to modify the process for imposing and collecting civil monetary penalties from skilled nursing facilities and nursing facilities found guilty by state or Federal inspectors of noncompliance with Federal patient-care standards.

The new regulations, first proposed in July 2010, are now in final form and will take effect January 1, 2012.

The new regulations are meant to implement one of CMS's new regulatory responsibilities set out in the new health care reform bill.

CMS's March 18, 2011 announcement from the Federal Register is on our website at http://www.nursinglaw.com/CMS031811.pdf

The new regulations themselves begin on Federal Register page 15126.

FEDERAL REGISTER March 18, 2011
Pages 15105-15128

Understaffing: Help To Bathroom Not Adequate On Night Shift, Patient Falls, Has Head Injury.

After hospitalization for pneumonia an elderly woman was admitted to a rehab facility for physical and occupational therapy and assistance with her ADL's.

She had been living with her son and the plan was for her to return home with him when she was ready.

Four days into her stay she fell during the early a.m. hours while trying to make it unassisted to the bathroom.

She sustained several subdural hematomas which rendered this once basically independent person now wheelchair-bound and dependent on others for 24/7 care.

The jury awarded her more than $2.2 million from the director of nursing, the administrator and the owner of the facility. The Court of Appeals of California upheld the jury's verdict.

The jury heard expert testimony that the patient's fall was caused by the facility's practice of deliberately understaffing the night shift.

Although two aides were needed on the wing where this patient was housed, only one was employed.

This practice of deliberate understaffing prevented the patient's need for safety being met when she had to use the toilet, despite her known risk of falling.

COURT OF APPEALS OF CALIFORNIA
February 28, 2011

In court the jury trial lasted more than six weeks. The case delved into every aspect of the patient's care including fall-risk assessment, care planning, medication management, use and non-use of restraints, diet, charting, bed height and the call button.

In the end, however, the jury's decision reportedly turned on the simple fact the facility deliberately only put one person on the night shift, resulting in no one being available to help her to the bathroom when she needed to go.

The facility's caregiving staff was fully aware of her fall risk, yet failed to provide sufficient staff to meet her safety needs.

The Court did reduce the jury's verdict to $1.27 million pursuant to California's damage-cap statute.

Saucedo v. Cliff View Terrace, 2011 WL 680212 (Cal. App., February 28, 2011).