LEGAL EAGLE EYE NEWSLETTER

August 2007 — *For the Nursing Profession* — Volume 15 Number 8

Labor & Delivery: Court Discusses Standard Of Care For Nurses Assisting In Delivery.

The Court of Appeals of Texas recently ruled that the jury's verdict exonerating the physician and the hospital's labor-and-delivery nurses would be left standing as a satisfactory resolution to a complex malpractice case seeking damages for profound hypoxic neurological injuries suffered by the baby.

The mother was fully dilated and the nurses had her pushing for over an hour when they decided they needed to summon the obstetrician.

The obstetrician right away suspected shoulder dystocia. He used a corkscrew maneuver to try to free the shoulder.

The obstetrician later testified that when shoulder dystocia is known or suspected, the proper course of action for the nurses assisting with the delivery is the McRoberts maneuver.

The nurses flex the mother's legs and push them toward her head while they apply pressure just above the pubic bone.

The problem in this case, it turned out, was not shoulder dystocia.

When the head emerged it was obvious there was a double nuchal cord, that is, the umbilical cord was wrapped twice around the baby's neck. He had to cut the cord at once to go ahead with the delivery.

Nurses assisting with delivery must keep themselves aware of the situation.

The nurses must be able to distinguish which actions can help and which can compromise the baby's safety.

Fundal pressure is contraindicated when shoulder dystocia is present.

Instead, the nurses should use the McRoberts maneuver.

COURT OF APPEALS OF TEXAS
July 12, 2007

Once the double nuchal cord was discovered and the cord was cut, the nurses were told to apply fundal pressure.

They push down on the upper abdominal area over the fundus of the uterus in an effort to force the baby out as expeditiously as possible.

In court all the experts agreed that fundal pressure is contraindicated when shoulder dystocia is present, that is, it does not help with shoulder dystocia and can actually delay the birth and harm the baby.

When shoulder dystocia has been an issue, fundal pressure is appropriate only after both shoulders have been released and are visible on the outside.

Ambiguous Nursing Documentation

The verdict was favorable to the nurses despite the nursing documentation being critically ambiguous. The jury was willing to accept the testimony of one of the nurses that her charting was not a correct reflection of what happened.

The nurse charted she and another nurse were, "instructed to push with fundal and suprapubic pressure," a notation which contains a potentially damaging fundamental contradiction on the crucial issue whether fundal pressure, as opposed to the McRoberts maneuver, was in use, and at which critical point in the delivery. **Banks v. Columbia Hosp., __ S.W.3d __, 2007 WL 2004852 (Tex. App., July 12, 2007).**

Inside this month's issue ...

August 2007

New Subscriptions

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Post-Op Care: Failure To Monitor O_2 Saturation.

After surgery to repair a hiatal hernia the sixty-two year-old patient went to a medical/surgical floor.

At 4:30 a.m. she was found unresponsive in her bed with her O_2 face mask off. Her O_2 sat had dropped to 48%.

The patient was revived, but not without brain damage that still affects her short-term memory.

The hospital and the surgeon pointed the finger of blame at each other.

The hospital claimed the surgeon erred not writing orders for the patient to go to the ICU post-operatively where she would have had continuous one-to-one nursing attention.

The surgeon claimed, as there was nothing in the nursing progress notes for four hours before the patient was found unresponsive, the hospital's nurses failed in their basic responsibility to monitor their patient's status.

After the hospital paid a settlement of $1,000,000 the patient elected not to proceed trial against the surgeon in the Supreme Court, Albany County, New York. **Lance v. Moores, 2007 WL 1977077 (Sup. Ct. Albany Co., New York, May 29, 2007).**

Chest X-Ray: Nurse Liable For Mix-Up.

A complicated failure-to-diagnose lung cancer case in the Superior Court, Santa Cruz County, California hinged, in part, on a nurse negligently sending the patient's physician the chest film from a year earlier, not the most current one.

He was a firefighter who was required to have yearly chest x-rays. **John Doe v. Unnamed Physician, 2007 WL 1765193 (Sup. Ct. Santa Cruz Co, California, February 13, 2007).**

Catheterization: Large Verdict For Nurse's Negligence.

The seventy year-old patient had had prostate surgery ten years earlier. At that time an artificial urinary sphincter was implanted.

He was admitted again to the same hospital where he had had the prostate surgery, this time for surgical correction of a small-bowel obstruction.

As routine post-operative care a nurse inserted a Foley catheter. In the process of inserting the catheter the patient's artificial urinary sphincter was damaged.

The patient now requires an indwelling urinary catheter.

The patient claimed he warned the nurse he "had a pump down there" but to no avail.

Pertinent Records Absent From the Chart

The court record revealed that the hospital records pertaining specifically to the catheterization were missing from the chart.

The nurse, who could not be identified, was not named as a defendant in the lawsuit, nor could the nurse be located to testify in court one way or the other about his or her actions.

Prior Hospital Chart Should Have Been Reviewed

The patient's attorneys argued to the jury that the hospital staff should have made themselves aware of his condition by taking a complete medical history and by reviewing any and all prior treatment records at the hospital.

Once his caregivers were aware of his condition, a urology consult should have been obtained before attempting urinary catheterization, the lawsuit claimed.

The jury in the Circuit Court, Lake County, Florida awarded the patient almost $500,000. The hospital was ruled 55% at fault for the nurse's negligence and the treating physician, associated with an independent medical practice group, was ruled 45% to blame. **Jacobs v. Leesburg Regional Medical Center, 2007 WL 1976951 (Cir. Ct. Lake Co., Florida, March 30, 2007).**

Sexual Assault: Nurse Had Assaulted A Patient.

A civil sexual-assault lawsuit in the District Court, Tarrant County, Texas resulted in a total settlement of $1,215,000 for the patient.

The hospital paid $315,000 and the insurance company for the nurse-staffing agency by whom the nurse-perpetrator was employed paid $900,000.

The nurse-perpetrator was convicted of sexual assault on a disabled person, a felony, and sentenced to 20 years in prison.

He sexually assaulted a partially paralyzed sixty-two year-old female stroke victim, a patient at the hospital.

Nurse Had Been Accused Of Prior Misconduct

Although his employment and criminal background checks were unremarkable, the nurse reportedly had been accused by another hospital patient of similar conduct just weeks before. The earlier assault was a key element tending to prove the patient's case. **Goodlett v. Adventist Health Systems, 2007 WL 1976779 (Dist. Ct. Tarrant Co., Texas, May 8, 2007).**

Falsification: Nurse's Firing Justified.

The US District Court for the Northern District of Indiana recently endorsed a nursing home's decision to terminate a nurse for errors in charting medications.

A habit of failing to initial the MAR for meds actually given is an error a nurse should be counseled to correct.

Initialing the MAR for meds not actually given is falsification of a medical record. That is much more serious and is grounds for firing, the court ruled. **Tucker v. Saint Joseph Care Center, 2007 WL 1970940 (N.D. Ind., July 2, 2007).**

Sexual Misconduct: Minor Patient's Acting Out Put Staff On Notice Of Potential For Abuse.

A recent case from the Superior Court, Los Angeles County, California, if widely followed elsewhere, will turn upside-down the traditional legal rules for assessing healthcare facilities' legal responsibilities and liability exposures in cases of sexual abuse of vulnerable patients by caregivers employed in the facilities.

The case was reported with the stipulation that the names of the patient and the private psychiatric hospital are to remain confidential. Not confidential, however, is the fact the lawsuit resulted in a settlement totaling $1,250,000, that is, $900,000 for the abused thirteen year-old female patient and $350,000 for her mother for her own mental anguish and emotional distress.

Facility Was Placed On Notice By Patient's Sexual Acting Out

In this case the patient's and her mother's attorney was prepared to argue that the private psychiatric facility was so preoccupied with increasing patient census to maximize profits that it neglected to take the precaution of conducting full background checks on male staff hired to supervise adolescent female psych patients.

However, there was no real proof of any deficiency in the background or work record of the male staff person in question.

In civil cases alleging sexual abuse by a caregiver in a healthcare setting, the threshold legal question has always been whether the facility had reason to anticipate that the perpetrator could and would abuse a vulnerable patient.

If the facility fulfilled its legal duty by fully investigating the caregiver's background and employment history and by closely tracking his behavior with vulnerable patients, and never found cause for alarm, the facility would not be held liable for the caregiver's conduct the first time an incident of abuse occurred.

That is not to say that the caregiver himself would not face the full range of civil and criminal consequences, whether it was part of a pattern or simply a first offence that his employer with reasonable diligence would not have anticipated.

SUPERIOR COURT, LOS ANGELES COUNTY CALIFORNIA
May 30, 2007

Instead, the facility's liability in this case stemmed from the sexual acting out of the adolescent female patient.

Her mother placed her in the facility because she was acting out promiscuously with boys basically her own age. In the facility she was diagnosed with depression and other psychiatric problems that made her vulnerable to sexual manipulation.

She repeatedly verbalized that she intended to have sex with the specific patient supervisor in question. No one seemed to pay any serious attention to her verbalizations. Then one day he alone was permitted to accompany her to what was described as a remote area of the facility where they engaged in sex in a bathroom.

The incident did not come to light until two weeks after the patient was discharged when she mentioned it to an adult who called and reported it to the police.

The staff member himself was arrested, convicted of a lewd act with a minor and sentenced to three years in prison.

The facility's legal counsel was prepared to go forward with the traditional defense argument in these cases that the facility had no reason, and the patient's legal counsel could point to no evidence, why the perpetrator should have been suspected, before the fact, of any propensity to act inappropriately.

Yet the facility agreed to settle on the basis it was the victim's, not the perpetrator's conduct which put the facility on notice of a potential problem, turning the traditional rules upside down. **Unnamed Patient v. Unnamed Private Psychiatric Hospital, 2007 WL 1765189 (Sup. Ct. Los Angeles Co., California, May 30, 2007).**

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Psych Meds: Court Discusses Criteria For Involuntary Administration.

Because a state-hospital patient verbalized a death threat toward a nurse, a court petition was filed to medicate him against his will with the anti-psychotic drug Risperdal.

The patient had been committed to the state hospital as a sexually violent predator and had been diagnosed as paranoid schizophrenic.

Disagreement with the medical judgments that went into the care plan, in and of itself, is not grounds for a court to order a patient to be medicated involuntarily.

A patient is entitled to object to the possible side effects of a psych medication.

Only if the patient completely lacks insight into the fact of his or her illness and the need for treatment is the patient considered incompetent to make his or her own informed decisions.

CALIFORNIA COURT OF APPEAL
July 9, 2007

The California Court of Appeal found that this patient was in complete denial that he had a psychiatric condition and as a result of his denial refused even to consider treatment with medication.

A patient is entitled to disagree with caregivers' plans and to voice objections to the side effects of a particular medication, as long as there is a basic insight that he or she has a mental illness and needs treatment. **People v. Simon, 2007 WL 1966120 (Cal. App., July 9, 2007).**

Prenatal Care: Mother And Fetus Are Both Considered To Be Patients.

The parents of a young child filed a complex lawsuit against the medical and nursing staff in attendance at the birth, alleging that malpractice in the manner of the delivery resulted in shoulder injuries to the baby leading to Erb's palsy and Klumpke's paralysis.

Later the parents amended their lawsuit to include the medical and nursing staff who had provided prenatal care. Specifically, the new allegations in the lawsuit claimed that the nurses who performed prenatal ultrasounds should have realized the fetus was large for gestational age.

Once the fetus is determined to be large for gestational age, the lawsuit contended, the legal duty of care owed to the fetus requires prenatal caregivers to recommend a cesarean delivery to the parents.

Medical and nursing staff providing prenatal care must be cognizant that the law considers the mother and the fetus both to be their patients.

Each patient has separate legal rights that can be enforced in court.

COURT OF APPEALS OF GEORGIA
July 9, 2007

The Court of Appeals of Georgia endorsed the premise of the parents' lawsuit inasmuch as they were suing on behalf of their child to enforce their child's legal rights, citing a policy statement from the American College of Obstetricians and Gynecologists to the effect that the fetus, as well as the mother, are the patients of prenatal caregivers. **Johnson v. Thompson, __ S.E. 2d __, 2007 WL 1965669 (Ga. App., July 9, 2007).**

FLSA: Are Personal Caregivers Entitled To Overtime?

The US District Court for the District of Maryland has a pending case which challenges the decision of a corporation which operates several care facilities to deny overtime pay to CNA's.

The US Fair Labor Standards Act (FLSA) mandates time-and-one-half overtime pay for most private-sector employees.

The Act contains an exception for employees in domestic service who provide companionship services for individuals who, because of age or infirmity, are unable to care for themselves.

The exception exists only for such services performed in clients' private homes.

UNITED STATES DISTRICT COURT
MARYLAND
July 5, 2007

The focus of the lawsuit is whether the CNA's provide personal care inside their clients' private homes, as opposed to inside a caregiving institution.

The definition of a private home is not at all straightforward in this case. The court must draw the line where progressive levels of assisted living cease to be private dwellings and become institutional.

At this point the court has ruled only that there will not be one, but four separate class-action lawsuits for the workers in four distinct levels of care offered by the corporation. **Rawls v. Augustine Home Health Care Inc., __ F.R.D. __, 2007 WL 1952988 (D. Md., July 5, 2007).**

Skilled Nursing: Court Reviews, Reaffirms Criteria For Medicare Part A Coverage.

The probate estate of a deceased former patient filed a lawsuit against the US Department of Health and Human Services seeking reimbursement under Medicare Part A for the patient's stay in a nursing facility following her hospitalization.

The US District Court for the Eastern District of New York reviewed in detail the Department's currently-accepted definition of skilled nursing services and concluded that the services provided to this patient were custodial in nature, rather than skilled nursing services, and were not covered by Medicare Part A.

The court expressly rejected a novel, more patient-friendly interpretation of the Department's regulations presented on behalf of the patient's estate. The argument rejected by the court essentially was that care-planning and charting by a licensed professional nurse of personal care and help with ADL's by non-licensed personnel is skilled care in and of itself.

Medicare Part A is a hospital insurance program covering inpatient care and certain post-hospital services including skilled nursing care.

To receive Medicare coverage for post-hospital skilled care, the beneficiary must have been an inpatient in a qualifying hospital for at least three consecutive calendar days, not including the day of the discharge, and must have been discharged in or after the month he or she became eligible for Medicare.

Further, the beneficiary must be in need of post-hospital skilled nursing care, be admitted to a skilled nursing facility and receive such care within thirty days after the date of discharge from the hospital. Medicare benefits include coverage for up to one hundred days of post-hospital extended care services during any spell of illness.

For Medicare to pay the costs of post-hospital extended care services, a physician, nurse practitioner, or clinical nurse specialist must certify and re-certify that such services are or were required because the individual needs daily skilled nursing and/or rehabilitative care for any condition for which the beneficiary received inpatient hospital services.

The court rejects the argument that skilled nursing services include management and evaluation of a care plan by a licensed nurse, when the actual services being provided to the patient are custodial rather than professional in nature.

Management and evaluation of the patient's care plan by a licensed nurse is a skilled nursing service when, due to the patient's physical or mental condition, the care being provided requires technical or professional personnel to meet the patient's needs.

UNITED STATES DISTRICT COURT
NEW YORK
March 19, 2007

The initial certification must be obtained at the time of admission of the beneficiary into the skilled nursing facility. An initial re-certification is required within fourteen days of post-hospital skilled nursing facility care.

Subsequent re-certifications are required at least every thirty days after the first re-certification.

In general, covered skilled nursing or rehabilitative services are (1) ordered by a physician; (2) require the skills of technical or professional personnel; and (3) are furnished directly by, or under the supervision of, such personnel. In addition, these services must be needed by the patient on a daily basis and must be ones that, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.

The list of services that do qualify as skilled nursing services includes:

(1) intravenous or intramuscular injections or intravenous feeding;

(2) tube and gastrostomy feeding;

(3) aspiration;

(4) insertion and replacement of catheters;

(5) application of dressings;

(6) treatment of widespread skin disorders;

(7) physician ordered heat treatments;

8) administration of medical gases; and

(9) rehabilitation such as bowel and bladder training programs.

Medicare expressly *excludes* coverage for items and services that are not medically reasonable and necessary, as well as "custodial services." Custodial services consists of care which does not satisfy the requirements for coverage as skilled nursing facility care.

Custodial personal care services that do not require the skills of qualified technical or professional personnel are not skilled services and therefore are not covered by Medicare. Such personal care services include administration of oral medication; bathing and treatment of minor skin problems; assistance in dressing, eating and going to the toilet; and general supervision of previously taught exercises and assistance with walking. These personal care services are considered custodial care and are generally not covered by Medicare.

However, overall management and evaluation of a care plan involving personal care services may constitute skilled services when, in light of the patient's condition, the aggregate of these services require the involvement of technical or professional personnel.

In addition, observations and assessment by a technical or professional person may constitute skilled service when such skills are required to identify the patient's need for modification of treatment or for additional procedures until his or her condition is stabilized. **Estate of Frohnhoefer v. Leavitt, 2007 WL 841917 (E.D.N.Y., March 19, 2007).**

Fall From Wheelchair: Facility Did Not Assess Patient.

An eighty-two year-old man had been admitted to a rehab center for physical therapy after hip replacement surgery.

Four days into his stay in rehab he fell out of his wheelchair.

The patient's lawsuit in the Superior Court, Orange County, California did not try to fault the facility for the fall.

Instead, the patient was awarded $421,570 because staff just looked for obvious signs of a head injury but did not fully assess his neuro status right after he fell.

At the hospital the next day a CT scan revealed he had had a stroke. The stroke apparently was what caused him to fall out of his chair. As a recent stroke victim he should have been given tPA within three hours to minimize potential damage from ischemia. **Jensen v. Longwood Management Corp., 2007 WL 1765191 (Sup. Ct. Orange Co., California, March 12, 2007).**

Fall From Bed: Wheels Not Locked, Facility Faulted.

The patient was recuperating in the hospital from a minor surgical procedure when he attempted to transfer, by himself, from his bed to a bedside commode.

The wheels of his bed were not locked. The bed moved just at the critical moment when he was trying to stand. He fell and tore the meniscus in his knee.

The Supreme Court of Louisiana ruled this was not a medical malpractice case. Therefore, the patient did not have to go before a medical review panel and did not need a medical expert to file a lawsuit. **Blevins v. Hamilton Medical Center, __ So. 2d __, 2007 WL 1866744 (La., June 29, 2007).**

Smoking: Unsupervised Patient Burned Badly, Dies.

A sixty-two year-old woman resided in a nursing and rehab center. Her medical problems included chronic obstructive pulmonary disease which required use of supplemental oxygen through a nasal cannula. She also used a wheelchair.

The patient wheeled herself into the nursing home's smoking area to smoke. With her oxygen in use she caught on fire. The flames were extinguished, but not before she had sustained second- and third-degree burns over 19% of her body.

At the hospital she told the medical staff she did not want to be intubated. She was pronounced dead the next morning.

Her adult children filed a lawsuit against the nursing home, the home's administrator and the director of nursing in the District Court, Dallas County, Texas.

The nursing home had a policy that residents were allowed to smoke, but only with supervision.

The resident's cigarettes should have been kept from her in a secure place.

The smoking room should have been secured and supervised by staff at any time any resident would be smoking in it.

DISTRICT COURT, DALLAS COUNTY
TEXAS
April 3, 2007

The lawsuit claimed damages for the deceased's pain and suffering based on failure to provide adequate supervision and a safe living environment.

The children were paid a $125,000 total settlement before the case went to trial. **Page v. Daybreak Venture, 2007 WL 1839824 (Dist. Ct. Dallas Co., Texas, April 3, 2007).**

Living Will: Patient Treated Without Her Consent, Jury Awards Family Damages.

A ninety-two year-old Alzheimer's patient resided in a nursing home.

She had a living will which prohibited the use of unnatural life-saving procedures.

The patient was intubated and catheterized when she became seriously ill. After the endotracheal tube and catheter were removed she lingered six more days still conscious before she finally passed.

Her daughter filed suit for negligence and non-consensual medical care in the Circuit Court, Palm Beach County, Florida.

The nursing home performed medical interventions without the patient's consent.

The nursing home failed to implement procedures to see that a patient's living will was placed in the chart and failed to train staff in the correct course of action in a medical emergency when a patient has a living will.

CIRCUIT COURT, PALM BEACH COUNTY
FLORIDA
March 7, 2007

The jury awarded $150,000 to the probate estate for the patient's conscious pain and suffering during her final ordeal.

The jury discounted the nursing home's arguments that its staff were not aware of the patient's living will and were automatically required to take emergency measures when any patient became seriously ill. **Estate of Neumann v. Morse Geriatric Center, 2007 WL 1828700 (Cir. Ct. Palm Beach Co., Florida, March 7, 2007).**

Medicare / Medicaid: CMS Proposes To Start Charging User Fees For Survey Revisits.

On June 29, 2007 the US Centers for Medicare & Medicaid Services (CMS) announced proposed new regulations to start charging user fees for Medicare and Medicaid survey revisits.

CMS's Federal Register announcement is on our website at www.nursinglaw.com/revisituserfees.pdf.

Any US Federal agency, before adopting new regulations, must first publish proposed regulations in the Federal Register and invite public comments.

The announcement includes instructions for members of the public who wish to submit their comments.

CMS will accept public comments until August 27, 2007.

At some point thereafter CMS will likely finalize new mandatory regulations.

CMS estimates the following as the average provider cost for each survey revisit conducted on-site:

Hospitals $2,554.00;

Skilled Nursing Facilities $2,072.00;

Nursing Facilities $2,072.00;

Home Health Agencies $1,613.00;

Hospices $1,736.00.

FEDERAL REGISTER June 29, 2007
Pages 35673 – 35864

PROPOSED NEW REGULATIONS
Published June 29, 2007

PART 424--CONDITIONS FOR MEDICARE PAYMENT

Sec. 424.535 Revocation of enrollment and billing privileges in the Medicare program.

(a) [grounds for revocation]

(1) Noncompliance. The provider or supplier is determined not to be in compliance with the enrollment requirements described in this section, or in the enrollment application applicable for its provider or supplier type, and has not submitted a plan of corrective action as outlined in part 488 of this chapter. The provider or supplier may also be determined not to be in compliance if it has failed to pay any user fees as assessed under part 488 of this chapter. All providers and suppliers are granted an opportunity to correct the deficient compliance requirement before a final determination to revoke billing privileges.

PART 488--SURVEY, CERTIFICATION, AND ENFORCEMENT PROCEDURES

(a) Definitions ...

Revisit survey means a survey performed with respect to a provider or supplier cited for deficiencies during an initial certification, re-certification, or substantiated complaint survey and that is designed to evaluate the extent to which previously-cited deficiencies have been corrected and the provider or supplier is in substantial compliance with applicable conditions of participation, requirements, or conditions for coverage.

Revisit surveys include both offsite and onsite review.

Substantiated complaint survey means a complaint survey that results in the proof or finding of noncompliance at the time of the survey, a finding that noncompliance was proven to exist, but was corrected prior to the survey, and includes any deficiency that is cited during a complaint survey, whether or not the cited deficiency was the original subject of the complaint.

(b) Criteria for determining the fee.

(1) The provider or supplier will be assessed a revisit user fee based upon one or more of the following:

(i) The average cost per provider or supplier type.

(ii) The type of revisit survey conducted (onsite or offsite).

(iii) The size of the provider or supplier.

(iv) The number of follow-up revisits resulting from uncorrected deficiencies.

(v) The seriousness and number of deficiencies.

(2) CMS may adjust the fees to account for any regional differences in cost.

(c) Fee schedule. CMS will publish in the Federal Register the proposed and final notices of a uniform fee schedule before it adopts this schedule. The notices will set forth the amounts of the assessed fees based on the criteria as identified in paragraph (b) of this subpart.

(d) Collection of fees.

(1) Fees for revisit surveys under this section may be deducted from amounts otherwise payable to the provider or supplier.

****

(2) Fees for revisit surveys under this section are not allowable items on a cost report, as identified in part 413, subpart B of this chapter, under title XVIII of the Act.

(e) Reconsideration process for revisit user fees. CMS will review revisit user fees if a provider or supplier believes an error of fact has been made, such as clerical errors. A request for reconsideration must be received by CMS within seven calendar days from the date identified on the revisit user fee assessment notice.

(f) Enforcement. If the full revisit user fee payment is not received within 30 calendar days from the date the provider or supplier receives notice of assessment, CMS may terminate the facility's provider agreement and enrollment in the Medicare program or the supplier's enrollment and participation in the Medicare program.

FEDERAL REGISTER June 29, 2007
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For the Nursing Profession

Patient Burned In OR: Too-Hot IV Bag Used For Positioning.

The patient was positioned on his right side for a procedure to remove kidney stones from the ureter on his left side.

After the procedure he had third-degree burns in the right axilla caused by the use of an overheated IV fluid bag placed there for positioning. The Court of Appeals of Texas approved a jury's award of damages for the patient's injury.

IV Bag Heated, Not Checked

Apparently the IV fluid bag was wrapped in a towel before being warmed for the patient's comfort in a microwave oven.

The court record was vague whether the towel was removed from the bag before it was used with the patient, but one way or the other no one noticed it had been overheated to the point it was hot enough to burn the patient. **Medina v. Hart, __ S.W. 3d __, 2007 WL 1933041 (Tex. App., July 5, 2007).**

C-2 Nerve Block: Post-Op Nurses Did Not Consult With A Physician.

After one and one-half hours in the recovery room following a C-2 nerve block for migraines the patient was discharged home by the recovery-room nurse, without checking with a physician, even though the patient was complaining of nausea and headache and was crying.

A few hours later the patient called and spoke with another nurse who told her to get her prescription filled for her anti-inflammatory medication and to lie down in a quiet dark room, also without checking with a physician.

The Court of Appeals of Georgia ruled there were grounds to sue the hospital for the nurses' negligence in failing to follow up for complications caused by the physician who had negligently injected the nerve block into an artery, as well as grounds to sue the physician himself. **Renz v. Northside Hosp., __ S.E. 2d __, 2007 WL 1732805 (Ga. App., June 18, 2007).**

Arbitration: Family Member Had No Authority To Sign For Patient, Estate's Case Will Go To Court.

In an effort to control damage awards and litigation expenses, many healthcare facilities are offering arbitration agreements to their patients.

In a recent case, however, the Court of Appeals of Georgia ruled the son's civil lawsuit against a nursing home seeking damages on behalf of the probate estate for his mother's death was not appropriate for arbitration and instead would be bound over for jury trial.

The Patient Never Agreed To Arbitration

Fundamental to arbitration of civil health care negligence cases is the requirement that the patient knowingly and voluntarily agree to arbitration.

In this case the patient's husband signed all the admission paperwork with the admissions counselor, including the facility's arbitration agreement, while other staff and family members were getting her settled in the facility.

There was no proof, the court said, that the husband had authority from his wife to sign a contract on her behalf.

The authority of an agent to act on behalf of a principal, the law says, must be made apparent by the statements or conduct of the principal, not the agent.

The facility could point to nothing that the patient herself had done, signed or said to a facility representative that would have conferred authority on her husband to sign on her behalf.

The husband himself was admitted to the facility for dementia soon thereafter and pre-deceased his wife. **Ashburn Health Care Center, Inc. v. Poole, __ S.E. 2d __, 2007 WL 1764217 (Ga. App., June 20, 2007).**

The nursing home could not prove that the patient gave her husband authority to sign an arbitration agreement on her behalf giving up her right to sue the nursing home in civil court.

The arbitration agreement does not bind the patient's son as executor of her estate any more than it would have bound the patient.

The case belongs in court before a civil jury.

COURT OF APPEALS OF GEORGIA
June 20, 2007