LEGAL EAGLE EYE NEWSLETTER

August 2008 *For the Nursing Profession* Volume 16 Number 8

Chain Of Command: Nurse Blamed For Neuro Patient's Death After Brainstem Herniation.

The twenty-four year-old patient, after several visits to the E.R. for headaches, was finally diagnosed with a left-sided occipital brain tumor. He was admitted to the hospital and scheduled for surgery.

At 1:05 a.m. the morning before surgery the patient's nurse observed his right pupil was fixed and dilated. The nurse immediately phoned the neurosurgeon who was scheduled for the surgery and reported what she had found.

The neurosurgeon ordered Dilaudid .5 mg for the patient's severe headache, one dose right away and another two hours later.

The neurosurgeon declined to do anything beyond ordering the Dilaudid. The nurse did nothing beyond giving the Dilaudid, that is, the nurse did not relay the patient's ominous change in status to anyone at the hospital.

At 6:00 a.m. the patient's temp was up, his BP was 190/90 and he was short of breath. At 6:30 a.m. he was unable to move his extremities. At 7:00 a.m in the pre-op holding area he stopped breathing and had to be intubated. The neurosurgeon finally looked at the MRI from the night before and started surgery around 11:00 a.m. for a fast-expanding occipital mass. The next morning the patient died from brainstem herniation.

The hospital's chain-of-command procedure had no specific instructions how a nurse was to advocate for a patient in a neuro emergency.

The nurse nevertheless should have known she had to take decisive action when the patient's physician would not come in to see the patient in a medical emergency.

COURT OF COMMON PLEAS
ALLEGHENY COUNTY, PENNSYLVANIA
May 23, 2008

The jury in the Court of Common Pleas, Allegheny County, Pennsylvania awarded the family $2,500,000 from the hospital, based on the testimony of two nursing experts and a neurosurgeon.

One nursing expert faulted the hospital for not having a chain-of-command procedure on the books detailing how a nurse was to advocate for a patient in a neurological emergency and for not including specific communication procedures for such emergencies in in-service training for nurses caring for neurosurgery patients.

The second nursing expert faulted the nurse herself for not getting a physician for her patient when she first saw the one-sided fixed and dilated pupil at 1:05 a.m. The nurse should have gone to the charge nurse or a supervisor and/or another physician and should not have quit until she got proper medical attention for her patient.

The family's expert neurosurgeon testified that life-saving surgery could have started many hours sooner to correct the patient's fast-changing medical status if the patient's nurse had set the wheels in motion when she first caught the problem. The neurosurgeon testified the nurse never actually reported a fixed dilated right pupil, only the same sluggish left pupil they had been seeing all day. **Rettger v. UPMC, 2008 WL 2663155 (Ct. Comm. Pl., Allegheny Co., Pennsylvania, May 23, 2008).**

Inside this month's issue ...

Patient Advocacy/Nursing Chain Of Command - Feeding Tube
Asthma Attack/Nurse's Error - Sexual Harassment - Patient Assault
Psych Nursing/Suicide Attempt - Labor & Delivery Nursing/Pitocin
Pulmonary Embolism/Post-Op Nursing Care - Nursing License
Alzheimer's/Nursing Facilities/Elopements/Supervision/Door Alarms
Nurse/Good Samaritan Act - Nurse/Disability Discrimination
Nurse/Freedom Of Speech - O.R./Positioning - Discharge Orders
Medications/Versed/Ambien - ADL's/Hands-On Assistance

August 2008

New Subscriptions
See Page 3

Feeding Tube: Nurses' Errors Led To Respiratory Arrest, Death.

The patient was admitted to the hospital with respiratory problems. Her physician ordered a nasogastric feeding tube and it was inserted.

The nursing staff discovered that the feeding tube had become occluded. The nurses removed the tube and put in a new one. Before feeding the patient the nurses obtained an x-ray. Some hours later the radiologist read the x-ray and called the floor to inform the nurses the tube was in the lung, not the stomach.

The nurses pulled out the tube, put it back in and called for another x-ray. However, before hearing back from the radiologist the nursing staff resumed feeding the patient through the tube, around noon on Saturday.

The radiologist did not read the new x-ray until 9:30 a.m. Sunday morning. In fact, the tube was again misplaced, this time through the trachea and left mainstem bronchus into the pleural space. The radiologist called the floor nurse and also called the patient's physician.

The patient's physician came to the hospital, only to find the patient was going into respiratory and cardiac arrest. Removal of a large amount of air and Ensure from her chest did not save her and she passed at around noon on Sunday.

The patient's probate estate filed suit only against the patient's treating physician and the hospital radiologist.

The Court of Appeals of Arkansas framed the issue as to the treating physician: were the nurses' chart notes that they had received verbal orders from him for two x-rays re tube replacement just routine chart entries at the hospital when nurses got routine x-rays on their own, or did the notes signify that the nurses had actually communicated with the physician about what was going on with the feeding tube?

The court ruled a jury would have to hear the evidence on the treating physician's liability, but dismissed the radiologist from the case. **Estate of Barnes v. Martindale, __ S.W. 3d __, 2008 WL 2514761 (Ark. App., June 25, 2008).**

Acute Asthma Attack: Nurse's Error Led To Brain Damage.

The judge in the US District Court for the Middle District of Florida awarded more than $4,000,000 from the US government for hypoxic brain damage suffered during an acute asthmatic episode by a nine year-old military dependent in a US military base hospital E.R.

Solu-Medrol and magnesium sulfate and breathing treatments with albuterol were not opening his airway so that he could breathe on his own. The patient was becoming combative from lack of oxygen. Lidocaine and Ketamine were given in preparation for rapid sequence intubation.

Nurse Gave Succinylcholine Contrary to Hospital Policy

Then the nurse went ahead and gave the succinylcholine, which almost immediately paralyzed the respiratory muscles.

It was clearly contrary to policy at the facility for the nurse to give succinylcholine, as opposed to the physician doing the intubation, a fact pointed out by the court as one of the bases for finding negligence was committed.

No one started bagging the boy's mouth for four minutes. Then it took almost twenty more minutes to intubate him, during which time he went into full-blown cardiac arrest. He now suffers from brain damage from oxygen deprivation.

Besides the nurse's error the court faulted the whole treatment team for rapid sequence intubation not being started until twelve minutes after the E.R. physician first determined that the medications were not opening his airway. **Turner v. US, 2008 WL 2726508 (M.D. Fla., July 1, 2008).**

Patient vs. Patient Assault: Caregivers Not Liable.

A jury in the Superior Court, Orange County, California ruled that the patient's medical and nursing caregivers were not at fault.

The patient had been admitted to the psychiatric facility for grave disability, that is, he was profoundly mentally ill and was unable to take care of himself on his own.

The patient assigned as his roommate had a history of criminal assault in the community. In the hospital the roommate had been diagnosed as a paranoid schizophrenic who experienced command hallucinations telling him to hit people.

The psychiatrist successfully defended himself in the patient's lawsuit on the basis that the roommate's illness appeared to be well controlled by medication.

The nursing staff was accused of not calling for an immediate full-scale staff response to restrain the roommate after the attack. The jury reportedly thought the nurses' response was substandard but saw no way it had anything to do with preventing the attack in the first place. **Cory v. La Palma Hosp., 2008 WL 2834197 (Sup. Ct. Orange Co., California, June 3, 2008).**

Harassment: Conduct Must Be Reported.

The Court of Appeals of Kentucky recently reiterated that healthcare facilities, like other employers, have serious responsibilities toward stopping sexual harassment in the workplace.

However, a nurse who believes a hostile environment is being created by a co-worker's conduct must report the co-worker before the employer's responsibilities and the nurse's rights come into effect. **Harper v. National Health, 2008 WL 2696899 (Ky. App., July 11, 2008).**

Psych Patient Jumps From Hospital Window: Psychiatrist, Psych Nurse Ruled Not Negligent.

The jury in the Superior Court, Middlesex County, Massachusetts agreed with State Department of Health investigators that the patient's caregivers were not at fault. His caregivers had no reason to foresee their patient would attempt suicide.

After he came to the E.R. having ingested gamma-hydroxybutyric acid and Klonopin over a period of four days the patient was involuntarily transferred to a psychiatric facility where it came out that the patient was self-medicating for intractable insomnia, not trying to harm himself.

His psychotic symptoms were diagnosed as side effects from the medications.

The psychiatrist ordered fifteen-minute checks which staff did conscientiously. The psychiatric nurse assessed her patient at the beginning of the shift and charted that he still had auditory and visual hallucinations and paranoid ideation.

However, the psychiatrist and the psychiatric nurse never had reason to handle their patient as a suicide risk. They were not at fault for not putting him on direct observation or other suicide precautions, the jury reportedly believed. **Jennings v. Li, 2008 WL 2747045 (Sup. Ct. Middlesex Co., Massachusetts, April 18, 2008).**

The patient never verbalized any suicidal ideation, intent or plan.

The psychiatrist and the psychiatric nurse both testified the patient was not suicidal or homicidal, based on their assessments.

The psychiatrist ordered checks every fifteen minutes. The psychiatrist also wanted frequent vital signs to monitor withdrawal from the drugs with which the patient had self-medicated for insomnia that were believed to account for his medication-induced psychosis.

The nurse had assessed the patient at the beginning of her shift, finding him still hallucinating and paranoid.

An aide had checked on him fifteen minutes before he threw a chair through a window and jumped out.

SUPERIOR COURT
MIDDLESEX COUNTY, MASSACHUSETTS
April 18, 2008

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924
© 2008 Legal Eagle Eye Newsletter
Indexed in
Cumulative Index to Nursing & Allied Health Literature™

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

E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
PO Box 4592
Seattle, WA 98194–0592
Phone (206) 440-5860
Fax (206) 440-5862
kensnyder@nursinglaw.com
www.nursinglaw.com

Patient vs. Patient Assault: Staff Knew Of Violent History.

The jury awarded more than $100 million punitive damages against the nursing home's parent corporation, but the Court of Appeals of Texas reduced the figure to $750,000 because of the state's statutory cap on damages for medical malpractice.

The nursing home's parent corporation was on a campaign to raise revenues by raising patient censuses at its facilities, according to the court record.

A patient was accepted from the locked psychiatric ward of a VA hospital. The new resident immediately began attacking other residents. The nursing staff insisted he be transferred to a facility that could securely handle him but the nursing home administrator refused.

He was given a new roommate who was not able to protect himself. Right away the problem resident assaulted and badly injured his roommate, who sued.

Violent Propensities Were Known But Ignored

Based on his violent history in and out of the nursing home the nursing home had good reason to expect the resident in question would act out as he did. That gave rise to a legal duty to take reasonable and necessary steps to protect other residents from his acting out. Failure to do so was ruled clear-cut gross negligence. **Casas v. Paradez, __ S.W. 3d __, 2008 WL 2517135 (Tex. App., June 25, 2008).**

Clip and mail this form. If you prefer, order online at www.nursinglaw.com
Print $155/yr ____ Online Only $95/yr ____ Phone 1-877-985-0977
Check enclosed ____ Bill me ____ Credit card ____ Fax (206) 440-5862
Visa/MC/AmEx/Disc No. ________________________________
Signature ______________________ Expiration Date ________
Name ______________________________________
Organization ________________________________
Address ____________________________________
City/State/Zip _______________________________
Email (If you want Online Edition*) ________________
*Print subscribers also entitled to Online Edition at no extra charge.
Mail to:
Legal Eagle
PO Box 4592
Seattle WA
98194-0592

Pulmonary Embolism, Death: Nurse's Post-Op Monitoring, Charting Faulted In Lawsuit.

On the morning of the day after transurethral prostate resection surgery the surgeon's partner ordered a transfusion because the patient seemed to be bleeding internally.

That afternoon at 3:22 p.m. the patient's wife went to the nurses station and told the nurse her husband was breathing heavily. The patient's nurse, according to the wife, told her the doctor knew about it and it was nothing to worry about and did nothing further.

Nursing Care Not Documented

In court some years later the nurse testified she phoned the surgeon immediately to report that the respirations had risen to 50, took vital signs, found they were normal, put on a pulse oximeter, which also gave a normal reading, and kept calling the physician's office.

None of this nursing care, however, was documented in the progress note the nurse put in the chart the next day based upon notes she claimed she had written down during her shift the day before.

The surgeon's office nurse testified a call was received from the hospital at 4:00 p.m. and the surgeon left for the hospital immediately. The surgeon testified he was on the phone with the hospital in his car and then called a code as soon as he got to the patient's room.

The family's nursing experts testified it is below the standard of care not to notify the treating physician and/or to advocate with a nursing supervisor or any physician who happens to be available when a patient is having a medical emergency.

Further, it is below the standard of care not to document nursing care completely at the time it is provided.

The jury reportedly accepted the spouse's and the physician's office nurse's version of events over the patient's nurse's testimony and returned a verdict against the nurse for wrongful death upheld by the Louisiana Court of Appeal. **Benefield v. Sibley, __ So. 2d __, 2008 WL 2669770 (La. App., July 9, 2008).**

The patient's nurse was guilty of several breaches of the standard of care.

The standard of care required the patient's nurse to contact the physician promptly when the nurse first observed that the patient's respirations had risen to 50 per minute.

The nurse claimed she made several attempts to reach the physician at his office. None of this was documented until the nurse wrote her progress note the next day. Even if it was true the nurse should have done more than just phone and leave messages.

The patient's nurse claimed it was her practice to make handwritten notes during her shift, then type her progress notes on the hospital computer system the next day. That is not acceptable nursing practice.

The nurse never documented taking vital signs during the critical two hours between the spike in the patient's respirations and when he was pronounced dead. Not documenting vital signs is below the standard of care; not taking them is inexcusable.

COURT OF APPEAL OF LOUISIANA
July 9, 2008

Elopements: Court Faults Facility's Actions, Civil Monetary Penalty Upheld.

After the resident's first elopement the facility got her a door-alarm ankle bracelet, but only the front door was alarmed and she went out again through a side door. After all the doors got alarms she figured out how to flip the switch to disarm the alarms and she eloped again.

The facility's response to the resident's third elopement, taping a piece of paper over the wall-mounted ankle-bracelet alarm bypass switch, would have stopped the average Alzheimer's patient, but it did not address this resident's individual level of cognitive ability.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
July 18, 2008

Staff taped a piece of paper over the alarm-disarm switch box, which probably would have confounded the average Alzheimer's patient but did not stop this resident from flipping the switch and eloping again. Finally a second buzzer was wired in to sound whenever the alarm was disarmed.

Alzheimer's – Patient Safety
Individual Cognitive Functional Capacity

The US Court of Appeals for the Fourth Circuit ruled that Federal regulations require a facility caring for Alzheimer's patients to tailor patient-safety interventions to the particular resident's level of cognitive functional capacity even if that happens to be significantly higher and therefore significantly more problematic to deal with than that of the average Alzheimer's patient. **Liberty Commons v. Leavitt, 2008 WL 2787675 (4th Cir., July 18, 2008).**

Elopement: Staff Ignored Door Alarm, Resident Fell, Broke Hip.

A lawsuit filed in the Superior Court, Orange County, California on behalf of an eighty-one year-old nursing facility resident resulted in a $988,000 settlement, reported on condition that the name of the facility be kept confidential.

The resident had been in the facility more than two years. She entered for supervision and personal care for dementia.

The facility did have door alarms. The alarm did sound when the resident walked out the front door. Two staff members on duty did not hear the door alarm.

It came to light that another staff member did hear the door alarm but was too busy talking on the phone to respond.

The resident walked several doors down the street, fell on the sidewalk, broke her hip and bruised her head. She was found after twenty minutes by a neighbor who notified staff at the facility.

The state Department of Social Services issued a citation for neglect. **Gladys v. Confidential, 2008 WL 2736715 (Sup. Ct. Orange Co., California, May 13, 2008).**

Elopement: Jury Awards Damages.

The eighty-seven year-old Alzheimer's patient walked away and reportedly remained AWOL for several hours before he was struck by a car and killed.

The facility reportedly was not state-licensed for dementia care; nor was it equipped to provide safe and secure care for dementia patients. The facility argued unsuccessfully in its own defense that the patient's spouse assumed the risk by checking him into a facility she knew was not licensed or equipped for the task.

The jury in the Superior Court, Los Angeles County, California rendered a verdict against the facility for $1,480,000 for wrongful death. **Wilson v. Eden Retirement Home, 2008 WL 2564683 (Sup. Ct. Los Angeles Co., California, March 1, 2008).**

Labor & Delivery: Pitocin Was Continued, Hyperstimulation Causes Hypoxia, Cerebral Palsy.

The family's pediatric neurology expert testified in court that the fetal brain sustained a parasagittal injury due to compressive forces that decreased blood flow in the watershed distribution as intracranial pressure exceeded the fetus's mean arterial pressure, resulting in hypoxic ischemic encephalopathy.

The compressive forces on the fetal head resulted from misuse or overuse of Pitocin by the physicians and nurses, causing hyperstimulation of the uterus in relation to the fetus's status within the womb.

The fetus's head was large and the pelvic opening unusually small, referred to as cephalopelvic disproportion, data known from the mother's last prenatal assessment before entering the hospital.

Further, the fetus's head was lodged in the persistent occiput posterior position for a number of hours, with no progress in labor, diminished variability and tachycardia on the monitor before contractions and persistent high resting tone, while the Pitocin was continued.

COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO
May 19, 2008

The jury in the Court of Common Pleas, Hamilton County, Ohio awarded the parents more than $24,000,000 from the hospital where their baby was born, compensation for the profound deficits their child, now ten years old, faces from cerebral palsy from hypoxic birth injuries.

Nursing and Medical Negligence

The parents' case hinged on medical testimony linking improper use of Pitocin to hyperstimulation of the mother's uterus which caused excessive and prolonged downward pressure on the fetus's head against the floor of the mother's pelvis.

Prenatal Care
Cephalopelvic Disproportion

The mother was twenty-two years old at the time and gravida one. At her last prenatal appointment, eight days before entering the hospital for cervical ripening and induction, she was diagnosed with a large baby and a narrow pelvic outlet.

Non-Emergency Cesarean Not Offered

After many hours of non-productive labor the infant was eventually delivered by cesarean, after the ob/gyn finally confirmed that the head was wedged above the pelvis and was not going to move any farther, period.

The mother, however, despite her known risk factors, was reportedly never offered the option of a planned cesarean.

Fetal Monitor
Intrauterine Pressure Catheter

According to the family's medical experts, the nurses and physicians attending to the labor failed to appreciate what the monitors had to say, that the uterus was hypertonic and the fetus was in distress. Instead of moving ahead with an emergency cesarean the Pitocin was continued, and that only tended to compound the problems the fetus was having.

The jury apparently discounted testimony for the ob/gyn that the catheter the hospital was using at the time was notoriously unreliable and could be ignored. **Grow v. Yang, 2008 WL 2736691 (Ct. Comm. Pl. Hamilton Co., Ohio, May 19, 2008).**

Disability Discrimination: Court Rules That Regular Attendance Is An Essential Job Function.

The US District Court for the Middle District of Pennsylvania rejected a registered nurse assessment coordinator's disability discrimination lawsuit she filed against her former employer.

The nurse had two back fusion surgeries for an old on-the-job injury. Her physician wrote a medical restriction for ambulatory dysfunction, meaning the nurse was not supposed to walk on wet surfaces. She began calling in any time it rained or snowed or rain or snow was forecast.

Her supervisors offered to provide van or taxi transport from her home to the front door or to transfer her back and forth from her parked vehicle via wheelchair. She refused to consider anything short of *carte blanche* permission to call in any and all so-called inclement-weather days.

Regularly Scheduled Attendance Is an Essential Job Function

Even if an employee has a legitimate disability, the court pointed out, the employee must be a qualified individual with a disability to be protected by state and Federal disability discrimination laws.

It is up to the employee to prove he or she is a qualified individual with a disability. The nurse herself admitted she was not able to come in to work on a regularly scheduled basis even with any of the reasonable accommodations offered to her.

She attempted to argue, instead, that she was qualified for her position even though she could not meet her employer's expectations for regularly scheduled attendance on the job.

The court ruled the nurse was not a qualified individual with a disability, that is, her disability discrimination lawsuit was missing a basic essential element.

No Retaliation In This Case

Supervisors have to be mindful that even if an employee or former employee does not have a valid discrimination claim, the employee cannot be subjected to retaliation for raising the issue, albeit unsuccessfully. **Flory v. Pinnacle Health, 2008 WL 2782664 (M.D. Pa., July 15, 2008).**

A qualified individual with a disability is an individual who can perform the essential functions of the position, even if it means the individual requires reasonable accommodation.

It is not reasonable accommodation to allow a nurse to call in on any and all inclement weather days, since regular attendance is an essential job function.

The supervisors discussed several reasonable accommodations, even an aide meeting her at her car with a wheelchair, but the nurse rejected everything short of being allowed to call in.

An employee who cannot come to work on a regularly scheduled basis is not a qualified individual with a disability and cannot sue for disability discrimination.

A supervisor had tolerated her calling in when it rained or snowed or looked like it might rain or snow.

However, giving someone a little bit of leeway does not impose a permanent ongoing burden on the employer to tolerate behavior that, for one reason or another, falls short of the employer's legitimate expectations.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
July 15, 2008

Good Samaritan Act: Nurse Dismissed From Lawsuit.

The school nurse was with her students at another district's school farm when the farm's resident caretaker's seven year-old son was poked in the eye.

The nurse volunteered to look at it. She merely told the parents to put some ice on it until the swelling went down.

Two days later their pediatrician found a piece of wire in the eye and sent the boy to an ophthalmologist. After several surgeries the eye finally had to be removed.

The New York Supreme Court, Appellate Division ruled the Good Samaritan Act applied and dismissed the nurse from the lawsuit. **McDaniel v. Keck, __ N.Y.S. 2d __, 2008 WL 2756498 (N.Y. App., July 17, 2008).**

Unless the nurse commits an act of gross negligence, a nurse cannot be liable for rendering first aid or emergency treatment at the scene of an accident or emergency, if it is done voluntarily and without the expectation of compensation and it is not done in a doctor's office, hospital or other clinical location that has proper medical equipment or supplies.

The nurse was not hired to care for this child. She volunteered in an emergency at or near the scene of the accident. The barn and the farmhouse are not clinical settings and had no supplies or equipment available for proper medical treatment.

NEW YORK SUPREME COURT
APPELLATE DIVISION
July 17, 2008

Nursing License Suspended: No Lawsuit Until Administrative Avenues Are Exhausted.

A nurse filed a lawsuit for damages against the State Board of Examiners for Nursing. After the Board had suspended her license she was unable to work and lost her home to foreclosure.

The Superior Court of Connecticut was able to rule in the Board's favor without having to look at the allegations of unprofessional conduct the Board had had to consider regarding the nurse.

Professional license suspensions and revocations are governed inflexibly by administrative procedures.

To challenge her license suspension the nurse was required to appeal at two successive levels within the Board and then to petition the Superior Court for review within the deadlines provided by state regulations. Her not having followed the appeal procedure, in and of itself, was grounds for dismissal of the nurse's suit against the Board. **Johnson v. Connecticut Board of Examiners for Nursing, 2008 WL 2745119 (Conn. Super., June 12, 2008).**

Operating Room: Positioning Error.

The Court of Appeal of Louisiana upheld the local parish judge's decision to throw out the jury's verdict of no negligence and to award damages to the patient.

When a patient is positioned for cervical surgery in the not-often-used seated position, all members of the hospital's surgical team are responsible for ongoing monitoring of chin-to-sternum clearance.

Reduced clearance could mean that carotid-artery flow is compromised; compromised carotid blood flow can cause a stroke. **Boxie v. Lemoine, __ So. 2d __, 2008 WL 2744238 (La. App., July 16, 2008).**

Freedom Of Speech: Nurse's Internal Memos Are Not Protected.

A registered nurse formerly employed in a hospital emergency room began writing memos about run-ins with nursing co-workers and other hospital personnel.

After she refused direction from her supervisor to do a nursing task that then had to be done by a nursing tech her unit director told her to report to employee assistance for a fitness-for-duty evaluation. The nurse declined and was terminated.

A nurse is protected by the Constitutional guarantee of Freedom of Speech when a nurse speaks out on a subject of public concern.

On the other hand, self-serving lists of personal grievances in memos to management dealing with the ordinary day-to-day job issues of a hospital nurse do not fall under Freedom of Speech.

The nurse has to be speaking out as a citizen, not as an employee doing an employee's job, for Freedom of Speech to come into play.

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
July 16, 2008

The US Court of Appeals for the Seventh Circuit ruled the nurse could not base her lawsuit against the hospital on the First Amendment guarantee of Freedom of Speech. All of the memos the nurse had sent to hospital managment pertained only to commonplace day-to-day happenings in the emergency department which were not subjects of public concern. **Davis v. Cook County, __ F. 3d __, 2008 WL 2746513 (7th Cir., July 16, 2008).**

Nursing License On Probation: Nurse Has No Grounds To Sue.

A nurse was charged with abuse for tying down an epileptic patient with bedsheets, a practice he knew was strictly forbidden at the facility where he worked.

With the advice of a lawyer the nurse agreed with the State Board to nine months probation during which he could work only in a setting where his nursing care would be monitored and regularly reported to the Board. The nurse, however, could not find an employer willing to accept his probationary practice restrictions and report regularly to the Board and his license could not be restored until he completed his supervised probation.

The nurse decided with perfect hindsight he would have been better off just to sit out ninety days unable to work with his nursing license under full suspension.

He sued the Board. The New Jersey Superior Court, Appellate Division, ruled the Board did not violate his rights by allowing him to enter into a probationary consent decree. **In re Odefemi, 2008 WL 2677872 (N.J. App., July 10, 2008).**

Discharge Orders: Mix-Up Leads To Overdose.

The elderly patient had a long history of heavy narcotics dosages for chronic pain. She was discharged to a nursing home after hospitalization for a fall at home.

The discharge order for 15 mg of morphine twice daily was transcribed as 15 mg and 30 mg doses each twice daily. The resident was also reportedly allowed access to alcohol at the nursing home. She died from acute morphine toxicity.

The jury in the Superior Court, Pima County, Arizona hit the nursing home with a $6,000,000 verdict for negligence. **Culpepper v. Manor Care, 2008 WL 2744197 (Sup. Ct. Pima Co., Arizona, April 14, 2008).**

Patient Falls: Nurse Faulted For Giving PRN Sleep Aid.

The seventy-four year-old patient was in the hospital recovering from a fractured hip.

Early in the evening the patient asked his nurse for something to help him sleep. The nurse phoned the patient's physician's partner who prescribed 10 mg of Ambien. During the middle of the night the patient got out of bed, fell and struck his head. Afterward his physician did not call for a CT scan until the patient had already become comatose from a subdural hematoma.

The nurse was faulted for the fall for giving 10 mg of Ambien when the maximum dose for a geriatric patient is half that. The nurse was also faulted for giving a prn sleep med when there was no prior charting that the patient actually had been having difficulty sleeping.

The Supreme Court of Delaware approved a $2,000,000 verdict split 60/40 between the nurse who gave the Ambien and the physician who treated the patient after he fell. **Christiana Care v. Crist, 2008 WL 2588704 (Del., July 1, 2008).**

Versed Overdose: Lawsuit Faults Nurse Monitoring During CT Scan.

The forty year-old patient came into the E.R. with abdominal pain which the E.R. physicians believed was related to kidney failure.

After waiting in the E.R. from noon until 3:00 a.m. the next morning the patient finally was sent to the radiology department for an abdominal scan. The patient was highly agitated by this time and was given several doses of Versed before the procedure actually began.

During the procedure the patient showed signs of over-sedation but the nurse standing by with him did not notice anything wrong until he had gone into full respiratory and cardiac arrest. A code was called. The patient was revived but has severe residual hypoxic brain damage.

The patient's lawsuit in the Superior Court, San Francisco County, California resulted in a pre-trial settlement of $6,000,000. **Weatherspoon v. San Francisco General, 2008 WL 2736708 (Sup. Ct. San Francisco Co., California, May 8, 2008).**

Patient Falls: High Seats On Commodes No Substitute For Hands-On Assistance, Jury Says.

A jury in the Supreme Court, Washington County, New York recently awarded $300,000 as damages for wrongful death in favor of the family of a now-deceased seventy-five year-old nursing home resident who struck her head when she fell off the high-rise seat on her commode.

It came to light in court that only one aide was assigned to a floor with twenty five residents when the resident used her call button to summon assistance to use the bathroom.

The one aide on duty was in the middle of helping to another resident and could not respond right away. Just as the aide finally did make it to the deceased's room she heard a loud thud and found the resident on the bathroom floor bleeding from a head injury.

Installing high-rise seats on the commodes, the deceased resident's family's lawsuit claimed, was intended as an alternative to having staff on duty to provide hands-on assistance to residents who needed help on and off the commode.

Beyond that, the seat itself did not fit the particular commode, making it even easier for the resident to fall off.

SUPREME COURT
WASHINGTON COUNTY, NEW YORK
May 12, 2008

The family's lawsuit alleged that the high-rise toilet seat was negligently installed, that is, it was the wrong item and did not fit this particular commode.

Further, state regulations require adequate staffing in long-term care facilities to provide hands-on assistance to residents who require it. A high-rise seat might help a resident get on and off the commode, but the jury's judgment was that that did not justify understaffing or failing to respond promptly to a resident's call for assistance.

The family's lawsuit also alleged the high-rise seat was provided without a physician's order, although it was never established conclusively that an order was required. **Estate of Nolan v. Washington County, 2008 WL 2663267 (Sup. Ct. Washington Co., New York, May 12, 2008).**