LEGAL EAGLE EYE NEWSLETTER

August 2009 *For the Nursing Profession* Volume 17 Number 8

Dementia Care: Court Finds Patient Abuse, Upholds Penalties Against Nursing Facility.

The eighty-seven year-old resident suffered from dementia and had a history of insomnia and falling.

After he fell and fractured his hip his physician ordered a soft safety belt to help restrain him when he was in his wheelchair.

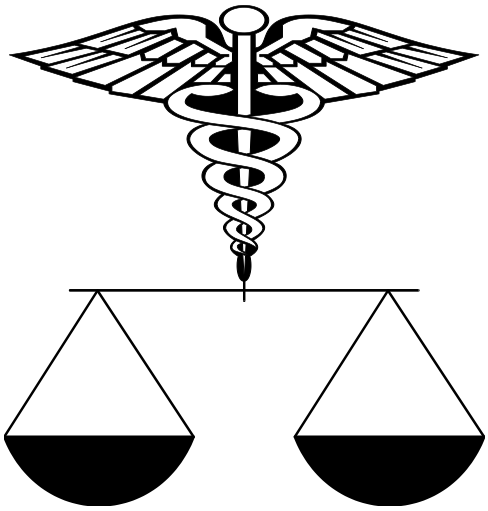
One early morning when he was still awake and sitting in his wheelchair at the nurses station he removed the soft waist restraint belt keeping him in the wheelchair and became combative with the two nurses at the station.

The nurses tried to prevent him from falling and tried to persuade him to give up the waist restraint. They called another nursing assistant to come and assist them because the one who was with the resident was physically too small to handle him.

While attempting to subdue the resident the nursing assistant grabbed the resident's right arm and tried to get the restraint out of his left hand.

After the resident pulled his arm away and refused to release the restraint one of the nurses asked the nursing assistant to let go of the resident's arm and then managed to persuade the resident to give up the restraint.

The nursing assistant then reportedly grabbed the resident's arms roughly while the nurses re-applied the restraint.



Federal regulations define abuse as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.

Physical abuse is presumed to have occurred when unjustifiable contact with a resident results in injury or harm to the resident.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
July 22, 2009

After the restraint was back in place the nursing assistant released the resident's arms, but the resident then removed his restraint for a second time.

This time when the nursing assistant tried to grab the resident's arms the resident started swinging at him. At that point the nursing assistant grabbed both of the resident's wrists and would not let go.

One of the nurses then suggested that the resident needed to go to bed, as it was past midnight.

The nursing assistant angrily answered, "He's not going to bed," and then wheeled the resident to his room to clean and change him because he had become incontinent either before or during the incident.

About ten minutes later the nursing assistant returned with the resident, who had been cleaned and changed.

The resident appeared upset and his eyes were watery and his lips were quivering. He pointed to his wrist and said to the nurse, "You broke my heart."

The nurse observed redness and edema on the resident's wrists three to four inches up his forearm, as well as redness on his hand. The resident told the nurse that it hurt, and when she touched his wrist he pulled away and said "ouch."

(Continued on page 5)

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Confidentiality: Other Patient's Records Held To Be Relevant.

The Superior Court of Massachusetts, Middlesex County, overruled a nursing home's objection to a court order that the nursing home provide copies to the attorney representing an assault victim of the medical records of another patient, the one who allegedly committed the assault.

The records were held to be relevant to the lawsuit because they would tend to reveal the extent to which the facility was or was not aware, prior to the date of the alleged assault, of the alleged perpetrator's propensity for violent acting-out.

The US Health Insurance Portability and Accountability Act and Federal regulations allow a medical facility to divulge confidential medical information when required to do so by a court order, subpoena, discovery request or other legal proceedings. **Mercier v. Courtyard Nursing Center, 2009 WL 1873746 (Mass. Super., June 11, 2009).**

EMTALA: Court Opens Up The Charts Of 96 Other E.R. Patients.

The US District Court for the District of New Jersey has ruled that the patient's attorneys are entitled to copies of the E.R. charts of ninety-six other patients who presented in the hospital's emergency department with chest pains in the two weeks before the patient's first visit to the hospital's E.R. for chest pains.

Patient-identifying information will be redacted as the charts are photocopied.

The charts were ruled relevant because the US Emergency Medical Treatment and Active Labor Act (EMTALA) imposes liability on a hospital whose E.R. does not provide a patient the same medical screening examination given to other E.R. patients with the same signs and symptoms. **Gonzalez v. Choudhary, 2009 WL 1025543 (D.N.J., April 15, 2009).**

Pressure Sores: Court Lets Photos Come In As Evidence.

The jury returned a verdict against a nursing home in favor of the personal representative of the probate estate of a deceased resident.

The lawsuit claimed damages for pressure sores that developed and progressed while the deceased was a resident at the facility. The family's expert witnesses said understaffing motivated by cost cutting and a general pattern of lack of concern for patients' welfare were to blame.

The judge must make a judgment call whether or not to admit gruesome photographs as evidence.

A piece of evidence that proves a point that is relevant to the lawsuit should not be excluded just because it might cause an unpleasant emotional reaction in the jury.

COURT OF APPEALS OF ARIZONA
June 25, 2009

The judge allowed the jury to view photographs of the patient's decubitus lesions, apparently taken by visiting family members. The judge's decision was a hotly disputed issue in trial and on appeal.

The Court of Appeals of Arizona acknowledged that the photographs were "gruesome."

However, there was no legal error in the judge's decision to let the photos come in as evidence. The photos did accurately depict the size and severity of the patient's wounds. The judge did not have to limit the evidence to prosaic verbal clinical descriptions of the lesions as the nursing facility's lawyer insisted.

Before allowing the jury to see the photos the judge verified their authenticity with three separate witnesses. **Estate of Fazio v. Life Care Centers, 2009 WL 1830719 (Ariz. App., June 25, 2009).**

Labor And Delivery: Nurses Did Not Advocate For The Patient.

Shoulder dystocia was encountered during the delivery, but the obstetrician reportedly insisted the nurses continue to apply fundal pressure.

The child was born with a brachial plexus injury which has resulted in complete loss of biceps muscle function in the affected arm.

The lawsuit filed in the Circuit Court, Covington County, Alabama resulted in a $700,000 settlement.

Had the case gone to trial, the nursing expert retained to testify on behalf of the mother and child was prepared to testify that it is below the standard of care for a nurse to continue to apply fundal pressure after shoulder dystocia has been encountered during the delivery.

Further, in the patients' expert's opinion, labor and delivery nurses have the duty at that point to advocate with the physician for a different course of action. **Powell v. Community Hosp., 2009 WL 1874340 (Cir. Ct. Covington Co., Alabama, April 23, 2009).**

Slip And Fall: Patient Needs No Expert.

The patient was admitted to a skilled nursing facility for a regimen of IV antibiotics for a bone infection.

He slipped and fell in the hallway where employees of the facility were stripping and re-waxing the floors.

The local county district court has not ruled one way or the other whether the facility was negligent.

The Court of Appeals of Texas has ruled it is not a healthcare liability case. The patient does not need an opinion from a medical expert to go forward with the case, even though it is a lawsuit for personal injuries against a healthcare facility where he was receiving medical treatment. **Dual D Healthcare v. Kenyon, __ S.W. 3d __, 2009 WL 1844332 (Tex. App., June 29, 2009).**

Developmentally Disabled Patient Assaulted: No Background Check For CNA.

The jury in the Circuit Court, Newport News, Virginia returned a verdict of $750,000 against an assisted living facility where a fifty-two year old developmentally disabled man was sexually assaulted repeatedly by the same CNA caregiver.

The victim reportedly has the mental capacity of a five year-old child and needs a high level of assistance with basic hygiene and other activities of daily living.

No Background Check Prior to Hiring

The perpetrator was hired with no background check.

Although he reportedly had no prior employment history or criminal history of sexual assault, his criminal record did include a lengthy list of offenses including assault and battery, larceny, public intoxication and failure to appear in court.

That was enough for the jury to conclude it was inappropriate to hire him or to permit him access to a vulnerable person. **Confidential v. Confidential, 2009 WL 1873353 (Cir. Ct. Newport News City, Virginia, May 28, 2009).**

Patient Suicide: Facility Not Liable.

When the patient was admitted to the psychiatric facility at 10:00 p.m. the charge nurse obtained orders from the on-call psychiatrist for a q 15 minute suicide watch.

The next morning the psychiatrist came in to see the patient. He was calm and cooperative and denied suicidal ideation. An antipsychotic med was ordered.

Later that morning a psychiatric nurse assessed the patient. He was withdrawn and isolated, but was not agitated and denied any suicidal ideation.

On a regular 15-minute check later that afternoon a psych technician found the patient had hanged himself with a bed sheet on the inside of his bathroom door.

The jury heard expert testimony from a psychiatrist and a psychiatric nurse faulting the facility but ruled the facility was not liable.

SUPERIOR COURT
LOS ANGELES COUNTY, CALIFORNIA
June 2, 2009

The twenty-seven year-old patient's father took him to the E.R. at the county hospital after he drew a knife and threatened to kill himself during the drive home from a bankruptcy court hearing.

He was held 24 hours, then transferred involuntarily to a private psychiatric facility that had a bed available.

The patient was seen and evaluated by the private facility's nursing, social work and medical staff. He was calm, cooperative and not agitated. Although isolated and withdrawn he consistently denied suicidal ideation. His diagnosis was rule/out major depression or psychosis. The plan was to start antipsychotic medication and hold the patient for observation.

The patient was on q 15 minute checks as a suicide precaution. It was documented before the fact that the checks were being done punctually and conscientiously.

Red Flag - Patient Inquired Who Was Doing the "Head Counts"

The family's nursing expert testified it was a red flag that should have alerted the nursing staff that a suicide attempt was imminent when the patient inquired at the nurses station which psych tech was doing the 15-minute "head counts."

In hindsight, the patient apparently wanted 15 minutes to himself between checks to carry out his plan to hang himself with a bed sheet in his bathroom.

However, the jury in the Superior Court, Los Angeles County, California did not find any departure from the standard of care in this patient's care and treatment and exonerated the facility from responsibility for his death. **Gonzalez v. Penn Mar Therapeutic Center, 2009 WL 1835152 (Sup. Ct. Los Angeles Co., California, June 2, 2009).**

Legal eagle eye newsletter
For the Nursing Profession
ISSN 1085-4924

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

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

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

Strep A: Nurses And Physician Jointly Liable For Pediatric Patient's Toxic Shock.

The six year-old had been ill for several days. He was acting sleepy and had a headache, sore throat and stomach pains.

His mother called the hospital's pediatric advice line. The nurse told her he probably had a virus and should drink plenty of fluids.

The next morning the mother called back. The advice-line nurse had a pediatrician return the call. The mother told her her son had diarrhea, red eyes, a fever of 103^{o} or 104^{o}, white spots on his tongue and stomach pains and was sleepy, vomiting and not urinating. The pediatrician said to phone for an appointment that morning at the pediatric clinic. The clinic nurse heard the same signs and symptoms over the phone and set an appointment for the child.

Minutes can make a significant difference in cases of sepsis.

If the mother had been told to take the child to the nearest E.R. most of the complications would have been prevented.

DISTRICT OF COLUMBIA
COURT OF APPEALS
July 2, 2009

The child collapsed before they got in the car. An ambulance rushed him to the Children's Hospital where he was treated for invasive Group A Strep and toxic shock. Both legs had to be amputated following multiple-organ-system failure.

The District of Columbia Court of Appeals wrestled with how to apportion the jury's $3,050,000 verdict between the hospital which employed the advice-line and pediatric-clinic nurses and the pediatrician. **Schoonover v. Chavous, __ A. 2d __, 2009 WL 1883703 (D.C., July 2, 2009).**

Ventilator, Extubation: Nurses Failed To Report Changes In Patient's Condition.

Settlement of a recent case from the Superior Court, San Bernardino County, California was reported on the condition that the names of the patient, the hospital and the individual caregivers be kept confidential.

The bulk of the multi-million-dollar settlement was to be paid by the hospital where the thirty year-old patient was taken after she passed out unconscious shortly after being released from another hospital's emergency department where she was only briefly examined and then released.

The patient was in the second hospital's ICU on a ventilator for nine days before the treating pulmonologist gave the order over the phone to extubate the patient, apparently without first ordering arterial blood gases.

Nurses Monitored, Charted Changes In O_2 Saturation Did Not Report to the Pulmonologist

The second hospital's ICU nurses saw that the patient's oxygen saturations were unstable, dropping at times to 90% and 91% during the first few hours after the respirator was discontinued.

The patient was also becoming increasingly agitated and combative at the same time.

Thick brown respiratory secretions were giving the nurses additional difficulty.

Although reportedly fully documented in the chart, none of the above information was conveyed to the treating pulmonologist before the patient had gone into full cardiac arrest and a code had to be called.

The patient was revived from her arrest, but not before profound brain damage had been caused by prolonged lack of oxygen. The patient now resides in another facility in a persistent vegetative state. **Confidential v. Confidential, 2009 WL 2047289 (Sup. Ct. San Bernardino Co., California, June 5, 2009).**

Chest Pains: Nurse Failed To Report To Physician.

The fifty-nine year-old patient was being observed in the emergency department overnight after an apparent allergic reaction to her cholesterol medication.

First thing in the morning she told the nurse she had started having chest pains. The nurse gave her Demerol and nitroglycerine but did not report to the physician.

The patient herself told the physician about her chest pains thirty minutes later when the physician came in to see her. The physician discharged her without further investigation.

Later that afternoon she died at home from cardiac arrest.

The jury in the Court of Common Pleas, Westmoreland County, Pennsylvania awarded a substantial verdict to the widow, 15% of which was apportioned to the hospital as the employer of the nurse who failed to report the patient's first complaint of chest pains for which the nurse gave Demerol and nitroglycerine. **Miller v. Latrobe Area Hosp., 2009 WL 1749292 (Ct. Comm. Pl. Westmoreland Co., Pennsylvania, May 14, 2009).**

Lab Tests: Results Not Brought To Physician's Attention.

The jury in the Circuit Court of Cook County Illinois awarded $2.6 million to the widow of a sixty year-old diabetic patient who died from an *E. coli* infection.

Blood tests ordered in the hospital's E.R. the day before the patient died showed signs of a serious bacterial infection, but the nurse reportedly only put the lab results in a file folder on the physician's desk and did not bring the situation to the physician's attention. **Crouse v. Memorial Hosp., 2009 WL 2013669 (Cir. Ct. Cook Co., Illinois, March, 2009).**

Dementia Care: Court Upholds Civil Monetary Penalties Against Nursing Facility (Continued).

(Continued from page 1)

When the nurse returned the next morning the resident showed her his right arm, which had dark bruises on the wrist.

The nurse had begun preparing a progress note on the day of the incident, a Friday, and completed it the following Monday.

The nursing assistant continued to work over the weekend and provided care to multiple residents, including this resident, without further incident.

The facility's director of nursing was not contacted on the date of the incident but only learned of it when she came in on that Monday and reviewed the weekend incident log.

That same day she began a routine investigation into the incident, starting with the nurse's progress note.

In a follow-up interview with the state survey inspector she later indicated that had she been on duty at the time of the incident, the nursing assistant would have been suspended immediately.

Instead, the nursing assistant was suspended on Tuesday and terminated later that week.

Facility Cited for Multiple Violations Of Federal Regulations For Nursing Facilities

The nursing home was cited for violating 42 C.F.R. § 483.13(b) which prohibits abuse of residents. Facilities participating in the Medicare and Medicaid programs are forbidden from using verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.

Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.

Interpretive guidelines state that a resident has been physically abused when

(1) Physical contact was made;

(2) The physical contact was intentional or careless;

(3) Physical harm resulted or physical injury, pain, or death to the resident was a likely outcome; and

(4) There was a lack of reasonable justification for the contact.

The nursing assistant handled the elderly resident angrily. What happened was not accidental and it was not necessary in providing care. It was intentional and retaliatory.

Physical contact while providing care, comfort or assistance to a resident is permissible when the type of contact and the amount of force used are absolutely necessary in order to provide care, according to the US Department of Health and Human Services State Operations Manual.

Physical contact that occurs in the course of attempting to restrain a resident's behavior in an emergency is permissible if both the type of contact involved and the amount of force used are reasonably necessary to prevent the resident from injuring himself or herself, injuring anther person or damaging property.

Squeezing any part of a resident's body is a specific example of potentially abusive treatment.

The nurse involved in the incident, as required by law, wrote a candid and detailed progress note which reflected accurately what really happened.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
July 22, 2009

The nursing home was also cited for violating 42 C.F.R. § 483.13(c)(2) which requires facilities to ensure that all incidents involving mistreatment are reported to the administrator of the facility and to officials in accordance with State law.

This section of Federal regulations also requires facilities promptly to investigate all allegations of abuse and the results of all investigations must be reported to the administrator or the administrator's designated representative and to officials in accordance with State law within 5 working days of the incident.

According to the court, it was irrelevant that the facility's director of nursing did not learn of the incident for two days. Federal law requires a report within five days of the incident. The time lag between the incident occurring and the director of nursing learning of the incident does not extend the Federal deadline.

Federal standards also require facilities to report incidents of abuse to state authorities within the time frame specified by state law. The court noted that the deadline for reporting abuse under state law (in North Carolina) begins to run when the health care facility itself, not any specified person, learns of abuse. In this case the facility learned of abuse when the resident himself alerted the nurse to the fact he had been injured.

In addition to reporting of incidents in compliance with Federal guidelines a facility is also required to set up effective policies for reporting of such incidents. Failure to implement such policies is a separate and distinct violation of Federal standards above and beyond what occurs in an incident and when and how it is reported.

Pattern of Abuse

The court endorsed the maximum civil monetary penalties allowed by law, on the grounds that a pattern of abuse and of inadequate response to abuse existed at the facility.

The nursing assistant continued working and was not dealt with promptly, nor were procedures in effect to deal with an alleged abuser promptly. Other incidents of less serious abuse had occurred. **Beverly Healthcare v. Leavitt, 2009 WL 2171235 (4th Cir., July 22, 2009).**

Post-Anesthesia Nursing Care: Physician Not Informed Promptly, Nurses Negligent.

During an aortofemoral bypass graft the surgeon completely clamps off blood flow to the patient's legs.

In this case the clamping continued for an unusual length of time because of abnormal calcification of the patient's renal arteries.

In the ensuing malpractice litigation the patient's own medical expert conceded the surgeon did nothing wrong. Instead, the finger of blame was pointed directly at the hospital's post-anesthesia care unit nurses.

Post-Anesthesia Care Unit Nursing Care

The patient's nurse performed an assessment as soon as the patient got to the PACU. Post-tibial pulses could be detected bilaterally with the Doppler and the patient was able to move both lower extremities without difficulty.

Shortly thereafter, however, the patient began to report persistent severe pain, loss of feeling in his legs and a sensation of pressure in his legs and pelvis. The patient's nurse began to notice that his legs were turning pale and were cool to the touch.

His blood pressure was low when he arrived in the PACU and continued to drop.

When the skin on the right leg began to show mottling the nurse then on duty finally contacted the surgeon.

The surgeon was first contacted concerning the changes in the patient's status at 8:40 p.m., the patient having arrived in the PACU at 6:42 p.m.

The Michigan Court of Appeals noted for the record that a different nurse than the one on duty at 6:42 p.m. took over the patient's care at 7:45 p.m. At that moment the nurse on duty was reportedly busy finishing her charting and left to go home at 8:05 p.m.

When the surgeon got to the hospital at 9:12 p.m. he immediately had the patient returned to the operating room for a second surgery. A blood clot was found and removed from the site of the graft done earlier that day.

The jury ruled that the hospital's post-anesthesia recovery nurses were negligent for the way they monitored the patient's condition and for the time they let go by before they reported to the physician.

An extended period of vascular occlusion led to ischemia, cell death and permanent damage to the muscles and nerves in the patient's legs.

COURT OF APPEALS OF MICHIGAN
July 16, 2009

The patient's malpractice lawsuit against the hospital alleged that the two nurses in the PACU were negligent.

The nurses were ruled negligent because they failed to contact the surgeon promptly to report signs of a post-surgical vascular emergency, which delayed the start of the second surgery.

The court rejected medical testimony that the clot was not there until right before the surgeon was called. The testimony was offered by a medical expert retained to testify for the defense.

The court found the testimony only speculative in that it was formulated after the fact for the hospital's defense. The court looked instead at the nurses' charting of events as they transpired.

When the second nurse took over she charted that the patient was already losing the ability to move his legs and was losing feeling in his legs, almost an hour before she notified the physician.

That was enough proof that there were signs that the problem had started, the nurses knew or should have known about it and should have reported to the surgeon, in the court's judgment. **Ykimoff v. W.A. Foote Memorial Hosp., __ N.W. 2d __, 2009 WL 2136289 (Mich. App., July 16, 2009).**

Medicare: New Regulations Define "Direct" Supervision Of Nursing Practitioners.

On July 20, 2009 the US Centers for Medicare and Medicaid Services (CMS) published an announcement in the Federal Register listing certain regulatory changes that will affect standards for Medicare reimbursement in 2010.

Definition of "Direct" Supervision Of Nursing Practitioners by Physician

CMS's announcement, among other things, clarifies the meaning of the word "direct" in the phrase "direct supervision" as it applies to physician supervision of nurse practitioners, clinical nurse specialists and certified nurse midwives.

For services provided in the hospital, direct supervision means that the physician must be present in the hospital or on campus and immediately available to furnish assistance and direction throughout the performance of the procedure.

For services furnished in an off-campus outpatient department, direct supervision means the physician must be present in the off-campus department and available to furnish assistance and direction throughout the performance of the procedure.

In or out of the hospital, the physician need not be present in the room when the procedure is performed.

FEDERAL REGISTER July 20, 2009
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Surgical Prep: Betadine Used For An Eye Procedure.

The patient, an elderly WWII veteran, checked into the local VA Hospital for eyelid surgery.

Known as blepharoplasty, the procedure is usually considered an elective cosmetic procedure done to improve the appearance of the patient's face. However, an ophthalmic surgeon recommended the procedure to this patient to remove sagging skin around his eyes to improve his peripheral vision. His visual acuity was 20/40 and 20/30 before the procedure.

During the procedure the patient suffered chemical burns to the corneas of both eyes resulting in corneal edema.

The US District Court for the Southern District of Mississippi ruled the medical evidence supported the conclusion that the problem was caused by the Betadine surgical prep getting into his eyes.

According to the court, the prep for eye surgery should be done with 10% Betadine solution diluted with sterile water to 5%. Full-strength Betadine surgical prep should never be used for the eyes, the court said. **West v. US, 2009 WL 2169852 (S.D. Miss., July 20, 2009).**

Labetalol: Nurse Not Negligent.

The patient, thirty-two years old and thirty-six weeks pregnant, was taken to the E.R. after a persistent cough progressed to real serious difficulty breathing.

The diagnosis was congestive heart failure due to an enlarged heart. The E.R. physician spoke with the primary-care physician and a cardiologist before ordering IV labetalol, an alpha and beta blocker with known risks associated with heart failure. The patient arrested and died.

The jury in the Superior Court, Essex County, Massachusetts faulted the physicians who ordered the medication but not the nurse who gave it. **Jardine v. Caritas Hosp., 2009 WL 2059773 (Sup. Ct. Essex Co., Massachusetts, January 22, 2009).**

Rehab Nursing: Expert's Opinion On Standard Of Care.

The elderly patient was admitted to a rehab facility after a stroke. Her medical diagnoses included diabetes, hypertension, coronary artery disease and congestive heart failure.

One morning the nurses discovered the patient's right leg was cool to the touch and did not have a pulse. The patient was sent to the emergency room.

A surgical procedure was started at the hospital to remove an embolism from the leg, but during the procedure the surgeon discovered that the leg was pre-gangrenous and amputated above the knee.

The patient died nine days later.

The expert hired for the family's lawsuit deduced from the medical records that the embolism was present and was causing arterial occlusion 24 to 36 hours before the nurses actually discovered it. That is, the leg was basically no longer salvageable when the patient got to the hospital.

A rehab patient's whole body should be checked daily for edema, for signs that the skin is abraded, torn or ulcerated and for the temperature of the skin to the touch.

Any significant findings must be reported to the physician.

COURT OF APPEALS OF TEXAS
July 2, 2009

The family's medical expert went on to state that the standard of care for rehab nursing mandates a daily body check.

The Court of Appeals of Texas accepted what the family's expert had to say about the standard of care and his conclusion that if the standard of care had been followed by the facility's nurses the patient's injury would not have occurred. **RGV Healthcare v. Estevis, __ S.W. 3d __, 2009 WL 1886889 (Tex. App., July 2, 2009).**

PCA Pump: Family Member Gave Morphine Dose, Thought It Was Call Light.

The eighteen year-old patient is now on a ventilator after respiratory difficulties encountered during a sickle-cell crisis.

The family sued the hospital alleging, among other things, that the father mistakenly gave his daughter an overdose of morphine by pushing the button on her patient-controlled analgesia (PCA) believing it was the nurse call light.

The New Jersey Superior Court, Appellate Division, ruled the hospital had refuted the allegations.

A physician testified that the PCA was properly calibrated. The amount of each morphine dosage and the time-out interval between dosages made it impossible for the patient to get an overdose which could have caused respiratory depression, apart from the unfortunate and unavoidable sequelae of the sickle-cell episode itself. **Tynes v. St. Peter's University Med. Ctr., __ A. 2d __, 2009 WL 2015069 (N.J. App., July 14, 2009).**

Mistreatment: Court Sees Grounds For CNA's Firing.

The nursing home's director of nursing observed a CNA shouting at an agitated wheelchair-bound dementia patient in the facility's dining room.

The director stepped in and tried to calm the resident and told the CNA to leave the room. The CNA stayed and continued yelling at the patient. A co-worker had to escort the CNA away.

The New York Supreme Court, Appellate Division, upheld the CNA's firing for misconduct, that is, for placing a resident at risk and ignoring a direct order from a supervisor. **Claim of Volmar, __ N.Y.S.2d __, 2009 WL 2176982 (N.Y. App., July 23, 2009).**

legal eagle eye Newsletter
For the Nursing Profession

Race Discrimination: Nurse's Claim Barred By Statute Of Limitations.

An African-American nurse went to work in 2004 at a state-operated psychiatric facility in an entry-level staff nursing position.

She already had her masters degree in nursing and reportedly was eager to advance her career. A representative from human resources informed her, however, that she had to work at the facility and remain in her entry-level position at least one year before she would be eligible to apply for promotion.

The nurse soon learned she was one of only four masters-prepared nurses working at the facility and that none of the other three, all Caucasian, had been hired in entry-level jobs.

Believing some sort of administrative oversight was the reason she was classified as employable only in an entry-level position she complained to human resources, then up the ladder to the director of nursing and even to her state assemblyman. All that went nowhere.

She resigned and applied for a position at another state facility. During the interview process she was informed it was being held against her that she had apparently abandoned her previous position.

After that she found out that the psychiatric facility also had hired a Caucasian nurse with only an associates degree directly into an administrative position.

Only at this point did the nurse first begin to believe that racial bias was a factor in the way she had been treated.

Nevertheless, the Superior Court of New Jersey, Appellate Division, dismissed her case that was not filed in court until 2007. No matter how valid a case might have been, it must be filed before the statute of limitations expires.

Discrimination Statute of Limitations Starts When Differential Treatment Occurs

The statute of limitations for a discrimination lawsuit begins to run when the victim is first treated differently and adversely compared to a non-minority, not when the victim first begins to believe that race may have been a factor. In this case that was when the nurse was first handed an opportunity that was clearly inferior to what was being offered to non-minorities with the same or lesser qualifications. **Henry v. New Jersey Dept. of Human Services, 2009 WL 2149880 (N.J. App., July 21, 2009).**

Labor Law: US Court Discusses Public-Policy Exception To Enforcement Of Arbitrator's Ruling.

Public policy for labor/management relations tells the courts to stay out of disputes covered by collective bargaining agreements unless one side or the other refuses to abide by an arbitrator's interpretation of the agreement and the authority of the Federal judiciary is needed, not to review, but simply to enforce the arbitrator's ruling.

Public policy for the health care industry strictly forbids abuse and neglect of vulnerable patients by caregivers and requires healthcare employers to remove employees who have been found guilty of such abuse or neglect.

The US District Court for the Eastern District of Michigan had to decide a case in which these two strongly-held public policies seemed to collide.

The night-shift aide was fired after the day-shift aide reported finding a patient lying in bed fully clothed in his own urine-soaked clothing an hour after the day shift had started.

A healthcare employer is not bound to accept and may file suit to challenge an arbitrator's interpretation of the collective bargaining agreement that ostensibly requires the employer to do something which violates public policy.

Restoring an aide to her job after she abused or neglected a patient, even if so ordered by an arbitrator, would violate public policy.

UNITED STATES DISTRICT COURT
MICHIGAN
June 19, 2009

The arbitrator ordered reinstatement. The District Court did not disturb the arbitrator's ruling.

The public policy requiring a healthcare employer to prevent abuse and neglect of patients would in most cases trump the public policy in favor of binding arbitration of a labor/management dispute covered by a collective bargaining agreement.

However, the arbitrator did not actually rule that the collective bargaining agreement compelled reinstatement of an employee guilty of abuse or neglect. The arbitrator found the evidence was not conclusive that she, not the day-shift aide, was at fault. **SEIU Healthcare v. Outer Drive Partners, 2009 WL 1803237 (E.D. Mich., June 19, 2009).**