LEGAL EAGLE EYE NEWSLETTER

August 2010 For the Nursing Profession Volume 18 Number 8

Antidepressant: Nurse's Advice To Patient's Spouse Implicated In Patient's Suicide.

The patient went to a US Veterans Administration medical facility in June, 2004 for treatment of anxiety. The physician prescribed a beta blocker and scheduled a follow-up visit.

At the follow-up visit the physician added the antidepressant Paxil and advised the patient to come back in two or three weeks at which time he would probably refer him for a psychiatric consult.

The patient's Paxil prescription was filled at the Veterans Administration pharmacy on July 6, 2004.

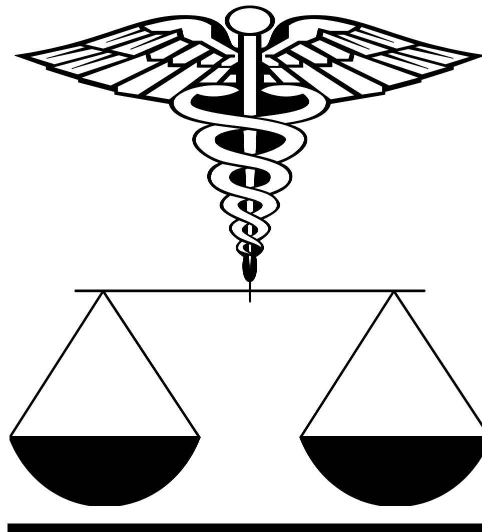
Two days later the patient's wife phoned the same facility and left a message that she wanted to discuss her husband's medication. A nurse decided to return her call.

The nurse looked up Paxil in the 2004 Mosby's Nursing Drug Reference during her conversation with the wife.

Based on what was in that reference source, the nurse told the patient's wife that it usually takes seven to ten days for an antidepressant medication to begin to work and to call back again if any changes in her husband's mood or behavior concerned her.

The patient committed suicide on July 23, 2004, his seventeenth day on the medication.

The widow sued the US Government and the drug manufacturer.



When a nurse counsels a patient or family member about the potential side effects of the patient's medication, the nurse has the legal responsibility to do so on the basis of up-to-date information.

This is especially important when a nurse talks with the patient or a family member without first consulting with the patient's physician.

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT
July 21, 2010

The lawsuit was based on the fact that the FDA had issued an advisory bulletin in March 2004 to inform health care providers of the risk of suicide in depressed patients newly started on antidepressant medications. Caregivers were alerted to watch for the emergence of agitation and irritability and worsening of depression.

In May 2004 the manufacturer had also circulated a letter to healthcare professionals with basically the same warnings as the FDA's advisory.

The drug reference book the nurse was relying upon, however, was published prior to and did not contain the FDA's or the manufacturer's recently circulated warnings about the potential for patient suicide or caution caregivers and family members about the signs and symptoms they should look for.

The US Court of Appeals for the Tenth Circuit ruled that a nurse who counsels a patient or family member about the potential side effects of a patient's medication has the legal responsibility to do so on the basis of up-to-date information about the medication.

The nurse's responsibility is especially acute when the nurse communicates with the patient or family without consulting with the patient's physician.
Van Dyke v. US, 2010 WL 2853722 (10th Cir., July 21, 2010).

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August 2010

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CDC H1N1 Infection Control Guidelines For Healthcare Facilities 2010
Post-Surgical Nursing/Respiratory Depression - E.R. Nursing
Labor & Delivery Nursing - Dilantin Overdose/Nursing Negligence
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Discrimination/Race/Pregnancy - Sexual Harassment/Nursing Home
Forcible Enema/Abuse/Neglect - Medication Allergy/Negligence

Uterine Bleeding: Patient Died From Hemorrhagic Shock.

The thirty-seven year-old patient delivered twins by cesarean section. Immediately afterward she developed a uterine hemorrhage for which her physicians performed a dilation and curettage and then a subtotal hysterectomy.

The patient was sent to the hospital's intensive care unit where the surgeon, her obstetrician and an ICU nurse were responsible for her care.

Her blood pressure weakened and she stopped passing urine. Several hours later she went into cardiopulmonary arrest. Her cardiac function and breathing were restored but she never regained consciousness and passed away one month later due to irreversible anoxic brain injury.

Despite signs pointing to internal bleeding and possible hemorrhagic shock, the patient's ICU nurse waited ninety minutes to draw blood for labs ordered by the surgeon after the patient's BP dropped and her urine output stopped.

SUPREME COURT
SUFFOLK COUNTY, NEW YORK
April 7, 2010

Her husband's lawsuit filed in the Supreme Court, Suffolk County, New York resulted in a settlement prior to trial.

Had the case gone to trial the experts would have faulted the ICU nurse for failing to appreciate the signs and take appropriate action for a patient losing blood internally to the point her kidneys had shut down as she was going into hemorrhagic shock.

The nurse and the hospital were also faulted for delaying the start of a blood transfusion once that was ordered by one of the physicians, apparently with no regard for the gravity of the situation. **Hall v. Porte, 2010 WL 2471792 (Sup. Ct. Suffolk Co., New York, April 7, 2010).**

Labor & Delivery: Large Settlement Paid For Infant's Cerebral Palsy.

The court settlement, paid to a bank as trustee for the infant injured at birth, apportioned liability 80% to the hospital and 10% each to the nurse midwife who was present during the delivery and the nurse midwife's supervising obstetrician who was not present and in fact was out of the country at the time.

Fetal Distress
Compressed Umbilical Cord
Vaginal Delivery

The mother was admitted to the hospital in labor at 2:10 a.m. The labor and delivery nurse saw a decrease in the fetal heart rate at 7:14 a.m. and again at 7:56 a.m. and notified the nurse midwife.

The nurse midwife did a vaginal exam at 8:06 a.m. and then phoned the obstetrician who was substituting for the nurse midwife's supervising obstetrician who was out of the country.

At 9:20 a.m. the mother was fully dilated. The nurse midwife had her start pushing. The fetal heart tracing disappeared. When it reappeared fourteen minutes later it was slower than it should have been. The nurse midwife applied fundal pressure to speed up vaginal delivery of the infant.

The infant experienced at least fifteen minutes of oxygen deprivation right before birth and is now a quadriplegic with profound developmental delays.

Had the case gone to trial in the Circuit Court, Cook County, Illinois, the family's nursing and medical expert witnesses were prepared to testify that the nurse midwife and the labor and delivery nurse, when umbilical cord compression was evident from the fetal heart tracings, should have started intrauterine resuscitation and turned the case over to an obstetrician instead of going ahead with vaginal delivery.

Major fault was also found with the hospital for failing to have a system in place to provide readily-available obstetrician support to a nurse midwife practicing at the hospital in the event a problem delivery was encountered. **Private Bank v. Sherman Health Systems, 2010 WL 2470540 (Cir. Ct. Cook Co., Illinois, April 15, 2010).**

Dilantin Overdose: Settlement Paid For Nursing Negligence.

The infant began having seizures two days after birth and was transferred to the hospital's neonatal intensive care unit.

Phenobarbital was started for the seizures but it was not effective, so Dilantin was ordered.

The Dilantin was reportedly ordered to be given to the neonate IM but the nurse gave it IV instead, causing a high concentration of the medication to enter the bloodstream quickly.

Immediately after the IV infusion the infant's heart rate slowed and his extremities cooled. After he was intubated his vital signs improved.

The child was later diagnosed with autism. It was hotly disputed in the lawsuit filed on his behalf in the Superior Court, Hampden County, Massachusetts whether the autism was or was not the result of the incident in the hospital.

Nevertheless the hospital agreed to pay a $6,000,000 settlement on his behalf. **Confidential v. Confidential, 2010 WL 2698345 (Sup. Ct. Hampden Co., Massachusetts, January 3, 2010).**

Med Allergy: Nurse Gave Wrong Drug.

The patient came to the E.R. with a sprained knee. She told the E.R. nurse she was allergic to NSAID's, aspirin, codeine and Toradol, all of which the nurse documented on the E.R. face sheet.

The E.R. physician, without seeing the patient or looking at her chart, ordered a Toradol injection to curb her pain while she was waiting to be seen by the physician. The same nurse who took her history of medication allergies reportedly was the one who gave her the Toradol.

The patient accepted a $17,500 settlement for an allergic reaction that involved airway obstruction and hives, but which resolved without further complications. **Holloway v. Pendleton Mem. Hosp., 2009 WL 6621488 (Dist. Ct. Orleans Par., Louisiana, June 29, 2009).**

Alzheimer's: Patient Poisoned By Caustic Alkali Solution Left In Facility Hallway.

A housekeeper had been using a toxic chemical solution to strip the wax from the floors in a nursing facility housing Alzheimer's patients.

The housekeeper left a paper drinking cup, one of the same cups the residents always drank from, full of the toxic solution on the handrail in a hallway.

An Alzheimer's patient woke up that morning, walked out of his room, picked up the cup and drank down all of the chemical solution in it.

The patient lingered in agony for sixteen days before he died. During the trial of the family's wrongful-death lawsuit in the County Court at Law, Dallas County, Texas the jury heard testimony that the caustic alkali solution caused liquefaction necrosis of his internal tissues, a horribly painful manner of death even with heavy doses of morphine and other analgesics.

The jury returned a verdict in excess of $3,000,000 to the family for negligence for the patient's pain and suffering in his final days. **Willis v. CC Young Memorial Home, 2010 WL 2635934 (County Ct. at Law, Dallas Co., Texas, May 7, 2010).**

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Psychiatric Hold: Hospital Nurse, Security Guard Entitled To Immunity From Patient's Lawsuit.

The patient was injured in a scuffle with a nurse and a security guard when the patient tried to walk out of the E.R. without treatment.

The nurse and the security guard had been told there was a 72-hour mental health hold in effect for the patient.

The nurse and the security guard were acting in good faith and were only doing their jobs. The patient has been unable to come forward with any evidence they were acting in bad faith, that is, intentionally engaging in a wrongful act without legal justification.

The patient's volatile behavior demonstrated he was in an unsound state of mind which required hospital employees to restrain him physically for his own personal safety.

COURT OF APPEALS OF MINNESOTA
June 22, 2010

The patient, who had a history of bipolar disorder, antisocial personality disorder and violence to himself, testified he was just stepping out from the E.R. to smoke a cigarette.

A hospital nurse and a hospital security guard testified the patient was trying to leave the hospital altogether right after he was told he was going to be kept for a 72-hour involuntary mental health hold.

Personal Injury Lawsuit Dismissed
Hospital Personnel Acted in Good Faith

The Court of Appeals of Minnesota dismissed the lawsuit filed by the patient against the hospital for the personal injuries he sustained in a scuffle with the hospital nurse and security guard.

The Court agreed with the patient that the hospital failed to follow the letter of the state's mental health law, in that the patient was not handed a copy of the involuntary hold paperwork as he was being informed that he was not going to be allowed to leave. However, that was not the issue.

The real issue was that the two hospital employees were immune from the patient's civil lawsuit for damages because they were acting in good faith with a legitimate belief that a valid 72-hour mental health hold was in effect. Their jobs not only allowed them but also required them to take all necessary steps to keep the patient from eloping from the hospital without treatment, for his own safety. **Cunningham v. Healtheast St. Joseph's Hosp., 2010 WL 2486319 (Minn. App., June 22, 2010).**

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Discrimination: US Appeals Court Strikes Down Race-Based Patient-Care Assignments.

A long-term care facility had an express policy calling for residents' racial preferences to be taken into account in assigning CNA caregivers.

The rationale was that doing otherwise would violate residents' rights to personal privacy and autonomy in making healthcare decisions, rights ostensibly guaranteed by state law and regulations defining Federal Medicare and Medicaid patient-care standards.

The daily patient assignment sheet posted for the CNA's had a column for miscellaneous treatment notes which expressly said "Prefers No Black CNA's" for certain residents. African-Americans were "banned" from interacting with such residents.

The CNA in question was also the object of racial slurs from her coworkers throughout her three months at the facility.

After she complained several times she was abruptly terminated for allegedly using a vulgar word for defecation while she and another CNA were assisting a white resident onto the commode.

Residents' Rights
versus
Caregivers' Rights

The US Court of Appeals for the Seventh Circuit had to resolve the apparent conflict between residents' rights to personal privacy, bodily integrity, autonomy and choice of healthcare providers *versus* the rights of minority healthcare employees to freedom from racial discrimination and hostility in the workplace.

The Court ruled that the facility's practice of honoring patients' requests for caregivers based on race was overtly discriminatory and violated Title VII of the US Civil Rights Act.

Beyond that, posting such requests from patients for all employees to see and abide by created a racially hostile work environment for African-American employees. The racist attitudes and behaviors of the other CNA's were the direct result of the racially hostile work environment the facility created, the Court said.

Gender-Preference Cases Are Not Analogous

Federal and state courts have ruled that a caregiver's gender can be a bona fide occupational qualification for a healthcare facility striving to protect a patient's personal privacy rights surrounding intimate personal care.

It is not gender discrimination not to allow an opposite-sex caregiver to provide such intimate personal care to a patient who has expressed a preference for a same-sex caregiver.

However, according to the Court, the personal privacy right that is violated when a patient is required against his or her wishes to undress in front of and/or be touched by a doctor or nurse of the opposite sex does not apply to race. The law tolerates same-sex restrooms and dressing rooms but not white-only restrooms or dressing rooms.

A healthcare employer can respect a patient's preference for a same-sex caregiver, but not same-race, the Court went on to say. **Chaney v. Plainfield Healthcare, __ F. 3d __, 2010 WL 2813644 (7th Cir., July 20, 2010).**

The work environment was racially hostile. That hostility came from daily reminders to the CNA that she was looked down upon as less than her white coworkers.

The daily assignment sheet noted some patients' preferences for "No Black CNA's."

Not only was that humiliating to her, it brought out racist attitudes and sanctioned racist behavior from other employees.

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
July 20, 2010

Post-Surgical Care: Changes In Neuro Status Not Reported.

The fifty-eight year-old patient came in for a CT scan after bouts of dizziness and blurred vision.

The scan showed a possible mass near the pineal gland. The mass was removed surgically. The post-operative orders included an MRI to be done that evening.

Troubling neurological signs seen during the night were not reported to a physician until the next morning.

A CT scan done in the morning revealed bleeding at the surgical site. A clot was surgically removed that afternoon, but the patient lingered in a persistent vegetative state for several months in a nursing home and then died.

The patient's Glasgow Coma Scale score was 12 when she was transferred to the neurosurgical intensive care unit.

Four hours later, around midnight, her score had dropped to 9 and her pupils, fully reactive before, had become sluggish, but the nurses did not notify the medical staff.

The MRI ordered for that evening was never done.

CIRCUIT COURT
WAYNE COUNTY, MICHIGAN
January 27, 2010

The husband's lawsuit filed in the Circuit Court, Wayne County, Michigan settled for $575,000.

The settlement was based on the hospital's nurses' failure to monitor the patient, failure to report her change in health status to a physician, that is, the drop in her Glasgow Coma Scale score and change in pupil reactivity, and failure to carry out the order for the MRI the evening after her brain surgery. **Brown v. Henry Ford Health Sys., 2010 WL 2488536 (Cir. Ct. Wayne Co., Michigan, January 27, 2010).**

Pregnancy Discrimination: Uniform Leave Policy Is Not Discriminatory.

Eight months after starting to work at the facility a nursing home employee gave her supervisor a note from her doctor stating that she needed to be off work until she gave birth due to her medical condition related to her pregnancy.

The facility's leave policy said uniformly that no employee was entitled to a leave of absence for any reason prior to one year on the job. There was no dispute that that policy was in effect when she was hired and that she was given a copy of the employee handbook outlining the policy.

She left work shortly before her due date and was terminated three days later.

A uniform policy for length of service for leaves of absence is not discriminatory in and of itself.

Pregnant employees are entitled to exactly the same treatment as others, not preferential treatment.

SUPREME COURT OF OHIO
June 22, 2010

The Supreme Court of Ohio ruled that the employee had no grounds to sue her former employer for pregnancy discrimination.

There was no evidence the employer's one-year service requirement prior to an approved leave of absence was intended to discriminate against pregnant employees or that the policy was applied in actual practice in a way that disadvantaged pregnant employees.

Pregnant employees are entitled under state and Federal pregnancy-discrimination laws to be treated equally with non-pregnant employees in all respects. The pregnancy discrimination laws do not entitle pregnant employees to preferential treatment. **McFee v. Nursing Care Management, __ N.E. 2d __, 2010 WL 2540720 (Ohio, June 22, 2010).**

Sexual Harassment: Jury Awards Damages To Housekeeper Who Complained.

A nursing home housekeeper repeatedly complained to her supervisors that she was being sexually harassed by certain residents when she went to clean their rooms.

She finally walked off the job in frustration after a series of heated discussions with facility management failed to bring about a solution that was satisfactory to her. When she phoned in to ask about her employment status with the facility she was told it was best they part company.

After she filed a complaint with the US Equal Employment Opportunity Commission she was rehired, with assurances that the harassment would be dealt with, and she continues to work at the facility.

An employer has the responsibility to combat sexual harassment on the job whether it comes from supervisors, coworkers or the employer's clients and customers.

An employer cannot retaliate against an employee who complains about sexual harassment from clients or customers.

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
June 25, 2010

The US Court of Appeals for the Seventh Circuit approved a judgment of $15,000 against the facility for the income she lost in the interim, plus $50,000 punitive damages.

The jury determined she had the right to walk off the job in frustration over her complaints not being taken seriously. She was not fired for unexcused absence. **Pickett v. Sheridan Health, __ F. 3d __, 2010 WL 2541186 (7th Cir., June 25, 2010).**

Obstructed Bowel: Patient's Death Related To Nursing Negligence.

The patient came to the emergency department with abdominal symptoms which called for his physicians to rule out a bowel obstruction. That meant doing a CT scan with oral contrast medium.

Before receiving the contrast medium the contents of the patient's stomach were to be cleared using a nasogastric tube.

Without starting the nasogastric tube the patient's nurses gave him the Dilaudid that was ordered for sedation during the CT scan. Then they had the patient begin swallowing the contrast medium.

The patient aspirated the contrast medium into his lungs as he became stuporous and then unresponsive from the Dilaudid. He had to be transferred to a teaching hospital where he died eleven days later.

The hospital agreed to settle the family's case filed in the Circuit Court, Wayne County, Michigan for $510,000. **Brooks v. Leone, 2010 WL 2852660 (Cir. Ct. Wayne Co., Michigan, March 20, 2010).**

Patient Chokes On Food: Nursing Home Settles.

The nursing home patient's care plan called for him to be supervised while eating. Allegedly due to understaffing at the facility, that is, too few CNA's on duty to supervise the residents properly, the patient was not discovered to have choked on his food until he became unresponsive during dinner. 911 paramedics suctioned pieces of food from his airway, one the size of a golf ball.

At first the facility claimed he simply had a heart attack and died while eating, but later agreed to settle with the family for $1,200,000 right before a binding arbitration hearing was set to begin. **Nelson v. Confidential, 2010 WL 2854345 (Tennessee, June 25, 2010).**

Neglect: Nurse Forcibly Gave Enema, Name Placed In Abuse Registry.

A resident of a long-term care facility had not had a bowel movement for several days. Facility policy called for a nurse to give him an enema.

His nurse asked him to lie in bed on his left side so she could proceed with his enema, but he got out of bed, refused to get back into bed and sat on the side of the bed with his feet firmly planted on the floor.

The nurse went out and told an aide to go to the room to help her. When the nurse returned the resident had wheeled himself to the bathroom in his wheelchair and the aide was helping him take down his pants so he could sit on the toilet and have a bowel movement on his own. The nurse chased him around the room, caught him and gave the enema while he was standing over the toilet. When he sat down and had his bowel movement blood dripped out of his rectum. The nurse went back to the nurses station and reportedly bragged that the patient had "fought like a bull."

The patient had to be taken to the hospital. His physician's assessment was that he was not injured but bled because he was on Coumadin and passed a hard stool.

Neglect means inattention to the physical needs of a patient or resident, including but not limited to toileting, bathing, meals and safety.

SUPERIOR COURT
SUSSEX COUNTY, DELAWARE
June 29, 2010

Although there was no evidence the enema injured the patient, the Superior Court, Sussex County, Delaware upheld the decision of the state Division of Long Term Care Residents Protection to place the nurse's name in the registry of persons found guilty of neglect of a vulnerable person in their care. **Sauers v. State of Delaware, 2010 WL 2625549 (Del. Super., June 29, 2010).**

Emergency Room: Communication Breakdown Leads To Patient Lawsuit.

The male E.R. patient had had an artificial urinary sphincter implanted surgically at the hospital. He had gone back to the same hospital one month later for a surgical modification, a constricting sleeve to correct urinary leakage. Two months after that he had gone back to the hospital for yet another adjustment.

Six weeks later he went to the same hospital again, this time to the emergency department, because of urinary retention.

He showed the E.R. personnel the medical information card that that same hospital had given him for his artificial urinary sphincter, just as he was instructed when he got it at the hospital.

Nevertheless, personnel in the emergency department tried to catheterize him without deactivating his artificial sphincter, causing a significant discharge of blood along with the urine.

After the bleeding alerted them that something was wrong a urologist was called in who quickly realized what the problem was and deactivated the device.

The Court of Appeals of Texas ruled that the patient's expert witness correctly outlined the standard of care and departures from that standard.

Effective Communication Is Necessary In the Emergency Department

Procedures were not in effect to ensure effective communication with a Spanish-speaking patient.

Regardless of any language barrier, after the patient showed them his medical information card which fully informed the E.R. staff about his particular medical situation and needs, that information was not shared among the nurses and physicians caring for him.

His chart from the hospital for his previous three admissions contained information that was obviously significant. However, his caregivers never looked up his prior chart before simply going ahead with a standard, routine medical intervention for his chief presenting problem. **Martinez-Partido v. Methodist Spec. Hosp., __ S.W. 3d __, 2010 WL 2838629 (Tex. App., July 21, 2010).**

Emergency Room: Court Finds EMTALA Violation.

The thirty-nine year-old patient came to the emergency room with abdominal pain, nausea and vomiting and said he had been constipated for four days.

He was given pain medication, an enema and manual disimpaction of his colon, but no lab tests or x-rays were done.

He was sent away in an ambulance at 12:40 a.m. The ambulance drove around to several relatives' homes who all refused to take him, returned him to the E.R. and then transported him to a nearby bed and breakfast. The bed and breakfast called 911 at 5:25 a.m. the same morning because he was vomiting blood. The same hospital discharged him again at 12:15 p.m.

The patient died that afternoon at a relative's home from purulent peritonitis caused by rupture of a duodenal ulcer.

The hospital chart itself showed that the patient was in severe pain and was vomiting blood. His respiration rate, hematocrit and white blood cell count were high and his red cell count and lymph percentage and urine output were low.

The patient was not stable at the time of discharge.

COURT OF APPEALS OF KENTUCKY
July 16, 2010

The Court of Appeals of Kentucky saw grounds for a lawsuit against the hospital by the family for violation of the US Emergency Medical Treatment and Active Labor Act (EMTALA).

The patient was discharged from the hospital in medically unstable condition which posed serious jeopardy to his health. The hospital had a legal responsibility to provide an appropriate medical screening and necessary stabilizing treatment, but failed to do so. **Thomas v. St. Joseph Healthcare, __ S.W. 3d __, 2010 WL 2812967 (Ky. App., July 16, 2010).**

Overdose, Death: Nurses Cleared Of Liability.

The forty-six year-old patient was admitted for elective plastic surgery.

She had a history of bipolar disorder and poly-substance abuse and dependence but did not reveal that history to her physician in her pre-surgical consult.

She reportedly did, however, tell her physician that she had a low tolerance for pain and a high tolerance for pain medication and would need to be kept well medicated while she recovered.

On the third post-operative day, while the patient was on a general medical-surgical hospital floor, she asked her physician and received more medication for pain than she had been getting.

Shortly after her pain medication was increased her oxygen saturation on room air dropped. One of the nurses put her on supplemental oxygen but did not report to the physician. Early the next morning the patient was found dead.

The oxycodone could not have reached the level found in the patient's blood during the autopsy unless the patient was self-medicating from an outside source right before she died in her hospital room.

SUPERIOR COURT
NORFOLK COUNTY, MASSACHUSETTS
March 17, 2010

The jury in the Superior Court, Norfolk County, Massachusetts found the nurse negligent who saw the drop in her O_2 sat but did not call the physician, but the jury also ruled that the nurse's negligence was not the cause of death. Another nurse and the physician were ruled not negligent.

The patient was far from candid with her caregivers about her drug history and apparently caused her own demise by secretly self-medicating. **Morad v. Russo, 2010 WL 2471432 (Sup. Ct. Norfolk Co., Massachusetts, March 17, 2010).**

Post-Surgical Nursing: Court Finds Departures From The Legal Standard Of Care.

The anesthesiologist was not at fault. It was reasonable for him to assume the nurses would monitor the patient, on heavy doses of morphine for pain, and report if anything went wrong.

The patient's oxygen saturation fell below 85%, maybe as low as 79%, but the nurses were not monitoring that.

A 101/59 blood pressure was obtained by a nursing assistant at 7:30 p.m. while the day nurse was occupied giving report to the night nurse coming on duty.

The patient's low blood pressure was troubling and should have prompted action because a patient in as much pain as this patient would tend to have an elevated, not a depressed blood pressure reading.

The nurses should have realized that a patient getting a lot of morphine who had this patient's assessment data was lapsing into respiratory depression and should have reported to the physician.

The patient and her husband are entitled to substantial damages for nursing negligence.

UNITED STATES DISTRICT COURT
FLORIDA
July 2, 2010

While recovering from surgery the patient experienced an episode of respiratory depression and hypoxemia related to her morphine intake. Permanent brain injury resulted.

The patient had been admitted for breast reconstruction following a battle with breast cancer. She received 10 mg of morphine during the two-hour procedure before being sent to the post-anesthesia care unit. For her intense post-operative pain her attending physician ordered more morphine prn as well as a morphine PCA pump. The patient received 9 mg of morphine in the post-anesthesia unit.

Transfer to Telemetry Floor
Not Placed on Telemetry

Several hours later the patient was transferred to the telemetry floor. On that floor, despite its designation, only some of the rooms were equipped for telemetry. For patients in the majority of the beds the nurses had to rig a baby intercom at the bedside to transmit the alarm to the nurses station if it should sound on the patient's PCA pump or pulse oximeter.

It was not done for this patient, but it would have been possible for the nurses, with or without a physician's order, to put on a pulse oximeter, to set the alarm to sound if the reading fell below 85% and to turn on the baby intercom to pick up the alarm if it sounded, according to one of the expert witnesses who testified at the trial in the US District Court for the Southern District of Florida.

Vitals Not Checked

Further, the patient's nurse herself did not check her patient or the vital sign data before giving report during the 7:00 pm to 7:30 pm time slot. She did not realize the patient's blood pressure was unusually low and did not report that to the night nurse coming on duty.

The night nurse found the patient in respiratory arrest when her husband summoned her to the room at 8:15 p.m.

The Court awarded her husband over $1.6 million for her future medical care. **Atkisson v. US, 2010 WL 2653452 (S.D. Fla., July 2, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

H1N1: New Guidance From CDC For The 2010-2011 Influenza Season.

On June 22, 2010 the US Centers for Disease Control and Prevention (CDC) published an announcement in the Federal Register containing specific updates for the upcoming 2010-2011 flu season for last year's *Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings*.

The CDC's recent announcement is extensively annotated with Internet links to informational resources on various facets of influenza infection control in healthcare settings.

The CDC was accepting public comments on its proposed updates until July 22, 2010 and then intends to issue a finalized guideline document for healthcare facilities' use during the 2010-2011 flu season.

The June 22, 2010 Federal Register announcement is available from the CDC at http://edocket.access.gpo.gov/2010/2010-15015.htm.

FEDERAL REGISTER June 22, 2010
Pages 35497-35503

Medicare/Medicaid: Proposed New Rules For Civil Monetary Penalties.

On July 12, 2010 the US Centers for Medicare and Medicaid Services (CMS) announced proposed new regulations to modify the process for imposing and collecting civil monetary penalties from skilled nursing facilities and nursing facilities found guilty by state or Federal inspectors of noncompliance with Federal patient-care standards.

The proposed new regulations are meant to carry out CMS's new regulatory responsibilities set forth in the recently-enacted health care reform bill. The proposed regulations are not mandatory at this time. CMS will be accepting public comments until August 11, 2010.

CMS's July 12, 2010 announcement from the Federal Register is on our website at http://www.nursinglaw.com/CMS071210.pdf.

The proposed new regulations begin on Federal Register page 39649.

FEDERAL REGISTER July 12, 2010
Pages 39641-39651

Quad Patient Verbally Abused Caregivers: Court Allows Facility To Discharge Him Involuntarily.

The forty-seven year-old patient entered the nursing facility following a period of hospitalization to treat a Stage IV pressure ulcer.

He is mentally competent, alert and able to speak for himself. However, as the result of his quadriplegia he cannot perform activities of daily living and is completely dependent upon others for all his most basic functions, including repositioning every two hours.

In response to his ongoing complaints about his care and caregivers the facility provided various forms of staff training specifically to address his individual needs, which proved unsuccessful at resolving his intense discontent.

The facility decided to issue a 30-day notice of involuntary discharge. Pursuant to Federal and state regulations a hearing was scheduled.

During his stay of more than a year at the facility the nurses and aides were rarely able to perform tasks and provide services to the patient's satisfaction.

He continually voiced his displeasure by badgering, berating and using profane, obscene, vulgar language toward staff members providing his daily care.

The medical director recommended a 30-day notice of involuntary discharge.

COURT OF APPEALS OF INDIANA
June 29, 2010

The hearing was held in the patient's room before an impartial examiner. The patient was present along with his sister, the facility administrator, social services director, director of nursing and RN and CNA caregivers familiar with his case.

The hearing examiner decided to allow involuntary discharge. That decision was formally adopted by the state Department of Health and then affirmed by the Court of Appeals of Indiana after the patient appealed.

The Court repeated *verbatim* for the record a string of vulgar obscenities from one particularly abusive tirade from the patient against a nurse caregiver. Unfortunately the record did not clearly detail how he was actually transferred to another care setting. **Dix v. Dept. of Health, 928 N.E. 2d 904 (Ind. App., June 29, 2010).**