LEGAL EAGLE EYE NEWSLETTER

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Post-Operative Care: Court Says Nurses Should Have Advocated For Their Patient.

The patient's right internal iliac artery was cut during lumbar laminectomy and diskectomy surgery, a fact the surgeon failed to spot before closing and sending the patient to the hospital's post-anesthesia care unit (PACU).

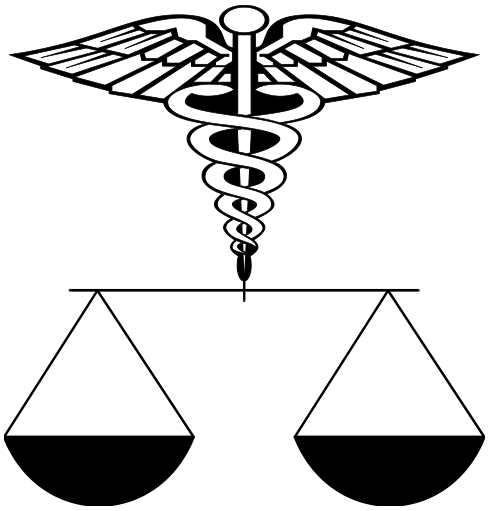
The patient ultimately died from hypovolemic shock caused by untreated internal bleeding.

Nurses Failed To Recognize the Signs, Advocate For the Patient

The Court of Appeals of Texas ruled the patient's family's nursing and medical experts' opinions correctly stated the standard of care for the PACU nurses and correctly related the patient's death to a breach of the standard of care by the nurses.

The nurses should have recognized the obvious signs of hypovolemia and realized that in a post-surgery patient it most likely indicated internal hemorrhage which could have fatal consequences if not addressed immediately by the treating physicians.

The patient's BP was 80/50 when she left the operating room and 88/31 in the PACU with a heart rate of 121. Her skin was pale and her abdomen had swollen to the point it resembled that of a woman in the late stages of pregnancy.



The standard of care requires a post-anesthesia recovery nurse to recognize the signs of hypovolemia and to act as the patient's advocate.

If the physicians refuse to come and see the patient the nurse must institute the chain of command by going to a nursing supervisor to get another surgeon and/or anesthesiologist to respond.

COURT OF APPEALS OF TEXAS
June 30, 2011

The nurses should have asked the surgeon to come to the bedside and consult with a vascular surgeon. They should have obtained orders for rapid infusion of intravenous fluids and at the same time taken steps to have an operating room readied for immediate surgery, in the experts' opinions.

Nurses not only have the right but also the legal obligation rapidly to institute the hospital's chain of command when the physicians treating the patient fail to take appropriate action.

Instituting the chain of command involves getting a nursing supervisor involved who has the clout to get another surgeon, vascular surgeon and/or anesthesiologist to come to the bedside to provide appropriate care.

Surgeon Also Faulted

Although the PACU nurses were guilty of errors and omissions which led to the patient's death, the family's lawsuit also faulted the surgeon for cutting the patient's artery in the first place and for closing without recognizing that he had done so.

In addition, there were issues raised about the physician-credentialing process at the hospital which allowed this surgeon to practice with a history of questionable outcomes. **Renaissance Healthcare v. Swan, __ S.W. 3d __, 2011 WL 2566275 (Tex. App., June 30, 2011).**

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PEG Tube: Nurses Mishandled Care, Failed To Advocate For The Patient.

The twenty-three year-old patient came to the emergency room with serious injuries from a motorcycle accident.

The physicians determined his injuries would not require surgery. While he was still in intensive care a tracheostomy was done and a PEG tube was inserted for tube feedings. Then the patient was transferred to a med/surg unit on his twenty-second day in the hospital.

The second day on the med/surg unit a nurse was attempting to flush the PEG tube when a loud "pop" was heard by the family who were present, although this was not charted in the nursing progress notes.

Vital signs afterward did show a decreased BP and increased heart rate, which the nurse reported to the on-call surgeon. The surgeon reportedly told the nurse to call the cardiologist, which she did, but the cardiologist never came in and the nurse did not follow up.

Early the next morning the nurse called the surgeon again and reported abdominal pain and an elevated pulse. She also told the surgeon the cardiologist never came to see the patient.

Two hours later the cardiologist was called again. He ordered medication and a transfer to the cardiac care unit.

The cardiologist and the surgeon came in a few hours after that and ordered a transfer back to intensive care. The ICU nurse called the hospitalist physician to report a pulse of 180, but it took the hospitalist two hours to come in.

The patient continued to deteriorate until early that afternoon when he coded but was revived. Later that afternoon he was taken to surgery. The g-tube was found free-floating in the abdomen along with widespread sepsis. The patient has remained in a coma ever since.

The bulk of the settlement of the lawsuit filed in the Superior Court, Riverside California was paid by the hospital for the negligence of the nurse who "popped" the PEG tube and the nurses who failed to coordinate the patient's care by appreciating the gravity of his situation and advocating for the physicians to respond in a more timely way. **Confidential v. Confidential, 2011 WL 2725234 (Sup. Ct. Riverside Co., California, January 3, 2011).**

Pediatric Patient: Nurse Fractured The Femur While Giving An Injection.

The eleven month-old infant was brought to the pediatrician's office for infections in both ears.

The physician prescribed medication to be given in a series of three IM injections over three days.

The third injection was administered by an registered nurse who reportedly applied excessive pressure holding him down and fractured the infant's right femur.

The mother called the office the next day concerned that the infant's leg was swollen and tender to the touch and was not moving as much as before. The nurse advised her that was normal after an injection and not to worry.

The parents brought the infant back two days and again four days after that. A physicians assistant and a physician diagnosed the problem as cellulitis and advised using hot compresses and massages.

The next day a pediatrician finally determined the leg was fractured and told the parents to take him to the emergency room. The diagnosis was a spiral oblique fracture of the femur.

The lawsuit filed by the parents on the infant's behalf in the Circuit Court, Palm Beach County, Florida alleged negligence by the nurse who used improper technique in restraining an infant for an IM injection as well as negligence by the clinic itself for providing inappropriate nursing supervision and negligent follow-up assessment and care when the problem was reported over the phone and the infant was brought to the office twice before the problem was finally recognized.

With approval from the Court the parents accepted a $100,000 settlement. **O'Quinn v. Pediatric Assoc., 2010 WL 6896501 (Cir. Ct. Palm Beach Co., Florida, December 15, 2010).**

Asystolic Patient: Court Faults First Responders.

A thirty-eight year-old corrections officer collapsed at the jail while playing basketball after work. He was unresponsive, was not breathing and his pupils were dilated.

A physicians assistant and a registered nurse, employees of a nearby hospital with the contract to provide on-site medical care at the jail, were the first to come to his aid.

They hooked up the defibrillator and quickly determined he was asystolic with possible V fib. There was no electrical activity in the heart. They tried to defibrillate with the paddles, starting with the lowest setting which was a 200 joule shock.

911 paramedics arrived eighteen minutes later. They immediately started an IV and gave epinephrine and then atropine. However, the patient could not be resuscitated and died.

The RN and the PA were both able to start IV's and should have known that the protocol for a patient in asystole is not to shock the heart but to start an IV, give epinephrine and atropine and intubate.

NEW YORK SUPREME COURT
APPELLATE DIVISION
June 30, 2011

As paid professional caregivers acting within the scope of their job duties, providing care to facility staff as well as the inmates, they were not entitled to the benefit of the Good Samaritan Law which would have exempted them from liability except for gross negligence, the New York Supreme Court, Appellate Division ruled.

The Court accepted expert testimony that shocking a patient in asystole is not indicated and can in fact damage the heart muscle and diminish the chances of survival. That this patient would likely have died anyway even with competent care was not an argument to which the Court was willing to open the door. **Estate of Murray v. St. Barnabas Hosp., __ N.Y.S.2d __, 2011 WL 2567782 (N.Y. App., June 30, 2011).**

Fall: Nurse Did Not Raise Bed Rail.

The New York Supreme Court, Appellate Division, was satisfied that the evidence supported a verdict finding negligence by the patient's nurse.

The sixty-three year-old patient was recovering from a below-the-knee amputation of his right leg necessitated by his diabetes.

Eight hours after the procedure he fell out of his hospital bed while reaching for his call button. He fractured his hip.

His wife gave a deposition in which she stated the nurse may have neglected to raise the bed rail again when she left the room after emptying his bed pan. If that was the case, in the opinion of the patient's expert witness, it would be a violation of hospital policy that the bed rails were to be raised for fall-risk patients during the time immediately after surgical anesthesia.

The jury awarded $3,000,000 to the patient's widow after hearing testimony about the patient's medical complications before and after the incident, including chronic renal failure for which he was in dialysis, amputation of the right foot, surgery for his fractured hip, amputation of the left leg after he fell and death from a heart attack. The Court found the jury's verdict excessive under the circumstances and ordered it reduced to $750,000. **Raniola v. Montefiore Med. Ctr., __ N.Y.S.2d __, 2011 WL 2555823 (N.Y. App., June 23, 2011).**

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Battery: Court Upholds Jury's Verdict In Favor Of The Hospital.

A person commits a battery for which he or she can be sued for damages in civil court if

The person had intent to cause harmful or offensive contact with the body of another person;

There actually was offensive contact with the victim which was harmful;

The victim was injured; and

The injury to the victim was caused by the person who committed the battery.

The jury decided that the hospital security guards who were directed by a nurse to prevent the patient from leaving the hospital against medical advice had no intent to cause harmful or offensive contact with the patient.

Blocking a patient from leaving against medical advice is not harmful or offensive contact.

APPELLATE COURT OF ILLINOIS
June 23, 2011

Four days after orthopedic knee surgery the patient became agitated and abusive when he was informed he was going to be discharged from the hospital.

He was upset with the fact he was being discharged and unhappy with the choices of discharge pain medications that the nurse was offering him.

The patient said he was leaving right away and was going to walk home on his own. He lived ten miles away and could barely manage on his crutches.

The nurse followed him down the hall into the elevator and through the main corridor on the ground floor. She or another nurse she asked to help told the hospital security guards on duty on the first floor to keep the patient from exiting.

The security guards informed the patient he was not allowed to leave and stood in his way. They did not grab him or restrict him except by standing in his way.

The patient, on pain medication and barely able to ambulate on crutches, fell trying to get through the revolving door by pushing it along with one of the crutches. He ended up in a wheelchair and was returned to the orthopedic floor by the nurse.

The Appellate Court of Illinois upheld the jury's verdict in favor of the hospital awarding no damages to the patient for civil battery. The jury apparently found no intent by the hospital security guards to cause harmful or offensive physical contact. As hospital employees they were basically caring for the patient by trying to block him from leaving. **Bakes v. St. Alexius Med. Ctr., __ N.E. 2d __, 2011 WL 2520137 (Ill. App., June 23, 2011).**

Labor & Delivery: Court Reviews Nurses' Legal Responsibility To Advocate For Patient.

The mother was already in labor when she was admitted to the hospital at 10:00 p.m.

At 1:30 p.m. the next afternoon the labor and delivery nurse charted that the mother was completely dilated but that the infant was not descending well despite good pushing efforts by the mother.

Twenty minutes later the ob/gyn tried repeatedly to get the infant out using a vacuum extractor over an interval of approximately twenty more minutes.

The extractor reportedly popped off multiple times, that is, the suction between the extractor and the fetal head broke down repeatedly due to the force being applied to pull out the infant being greater than the device was meant to withstand.

Then the ob/gyn went in with forceps to grasp the head and got the infant out. The infant was transferred to a tertiary care facility with multiple cranial injuries.

Legal Standard of Care
Labor & Delivery Nurses

The hospital's first line of defense to the lawsuit filed against the hospital by the mother and on behalf of the infant was to challenge the patients' nursing and medical experts' opinions on the legal standard of care applicable to labor and delivery nurses under the facts of the case.

The Court of Appeals of Texas ruled the experts did, in fact, correctly state the standard of care.

The ultimate issue, whether the ob/gyn would have listened and switched to a cesarean instead of the vacuum extractor and forceps, or done a cesarean earlier, will have to be decided by the jury when both sides finally have their day in court.

Duty to Advocate for Patient

According to the patients' nursing expert, a labor and delivery nurse is expected to review the prenatal records for problems and correlate these findings to the labor and delivery process.

The nurse should understand the clinical significance of protracted labor disorders, particularly when concerns have been documented over the size of the mother's pelvis in relation to the size of the fetal head, referred to as cephalopelvic disproportion.

The patient's nursing expert correctly stated the standard of care for labor and delivery nurses.

The jury will have to decide the ultimate issue, that is, whether the physician would have listened and the nurse's advocacy would have changed the outcome.

The expert alleged the nurses failed to advocate on behalf of the mother and the baby.

The nurses failed to use the hospital's chain of command policy to advocate for a change in the medical plan as required by prudent nursing practice.

The nurse failed to recognized the clinical significance of the long and protracted labor curve during delivery.

The nurse failed to advocate against vacuum extraction or use of forceps to shorten delivery.

The nurse failed to recognized the significance of the mother's narrow pelvic arch and the need for a cesarean delivery.

Cephalopelvic disproportion is a condition in which the size of the pelvis is small in relation to the fetal head. It can make a safe vaginal delivery difficult or impossible.

COURT OF APPEALS OF TEXAS
June 23, 2011

The labor and delivery nurse is expected to be a patient advocate and to understand the hospital's chain of command policies.

In the event a nurse identifies a clinical scenario that could jeopardize the well-being of a mother or baby, the nurse is expected to advocate for a change in the medical plan.

The labor and delivery nurse is expected to have a basic understanding of the indications and contraindications for operative vaginal deliveries, including the use of vacuum extraction and forceps.

Vacuum extraction and forceps are contraindicated in a patient with a dysfunctional labor, arrest of descent and a narrow pelvis. The use of both vacuum extraction and forceps is contraindicated in any given case, the patients' nursing expert said.

In this case the nurse should have requested a conference with the physician and a charge nurse and implemented the hospital's chain of command on the issue of whether to proceed with a vaginal birth.

The nurse should have questioned the safety of continuing with the Pitocin to augment labor, discussed the significance of cephalopelvic disproportion and raised the possibility of a cesarean delivery.

The nurse noted in her own nursing documentation that the infant was not descending well despite good pushing efforts.

The patients' nursing expert went on to relate the infant's cranial injuries, skull facture, epidural and subdural hemorrhages and facial lacerations to the improper use of the vacuum extractor and forceps during delivery, which would have been avoided if the ob/gyn had performed a cesarean delivery.

In the nursing expert's opinion, advocacy by the labor and delivery nurse clearly would have avoided the unfortunate outcome.

The Court, however, while convinced the nursing expert had very ably stated what the nurses should have done and explained the rationale why, it was not her place as an expert to decide the ultimate outcome of the lawsuit, that being the job of the jury. **Weatherford Texas Hosp. v. Riley, 2011 WL 2518920 (Tex. App., June 23, 2011).**

FMLA: Court Says Injured Nurse's Legal Rights Were Not Violated.

A med/surg nurse had an on-the-job neck and shoulder injury which made her unable to lift at least twenty-five pounds as required by the hospital's job description for a bedside nurse.

She was allowed to participate in a special program which provided light duty to injured care-giving employees to assist in their transition back to full-duty status.

The program required, however, that the employee provide proof through reports from the treating physician of progress toward successful resolution of the employee's job restrictions and toward return to work without those restrictions.

The nurse was not able to demonstrate such progress and was therefore told to take medical leave. After her leave was used up she was not able to return on full-duty status and was terminated.

The US Family and Medical Leave Act (FMLA) does not require an employer to provide light duty for an employee who cannot meet the physical demands of his or her position.

UNITED STATES DISTRICT COURT
OHIO
June 23, 2011

The US District Court for the Western District of Ohio ruled the nurse had no grounds to sue her former employer for violation of the US Family and Medical Leave Act (FMLA).

The nurse was not entitled to remain on light-duty status and use her medical leave intermittently as she needed it. Normally an employee who is eligible for FMLA leave can use it in large chunks or intermittently as needed, but that assumes the employee will return to full-duty status when the leave is over, after many weeks or just a few days, which was not the situation in this case. **Kleinser v. Bay Park Comm. Hosp., __ F. Supp. 2d __, 2011 WL 2474217 (W.D. Ohio, June 23, 2011).**

Religious Discrimination: CNA's Lawsuit Dismissed By Court.

Title VII of the US Civil Rights Act requires an employer to make reasonable accommodation to an employee's religious observances, so long as it does not cause an undue hardship to the employer.

An employee can sue the employer if the employee can prove that he or she had a bona fide religious belief that conflicted with an employment requirement, that he or she informed the employer of the belief and that he or she was disciplined or discharged for failing to adhere to the employment requirement in question.

In this case, however, there is no evidence the employee had a bona fide religious belief that required her to pray at certain times of the day or that she was unable to pray because of a requirement of her job.

She never told her supervisor that she needed to pray during her lunch or break times or that she needed to take her breaks at certain times to pray.

Nor is there any evidence the employee was discharged for praying or that the employer failed to make reasonable accommodation to her religious practices.

UNITED STATES DISTRICT COURT
MISSISSIPPI
June 24, 2011

A CNA used her lunch breaks as times to pray at work.

She claimed she was criticized by her co-workers for praying. After she complained to her supervisor, she was denied additional training that she requested and then was fired.

She sued her former employer, claiming religious discrimination, failure to provide reasonable accommodation to her religious beliefs and practices, retaliation and a hostile work environment. The US District Court for the Southern District of Mississippi dismissed her lawsuit.

No Religious Discrimination

The CNA's lawsuit ignored one basic legal requirement. She had to prove that the person who replaced her had different religious beliefs and practices than hers.

Secondly, the employer had legitimate non-discriminatory grounds to terminate her for insubordination. She apparently "crashed" an on-the-job in-service training session she wanted to attend but was expressly not authorized to attend because she was not yet qualified with her length of time on the job. Blatant refusal to follow directions from a nurse manager is grounds to terminate a CNA.

No Failure to Provide Reasonable Accommodation

The CNA had no proof she required reasonable accommodation above and beyond being able to pray when her supervisor happened to let her take her breaks.

An employer must make reasonable accommodation to an employee's religious beliefs and practices, but only after the employee expressly asks for such accommodation and only to the point it does not cause undue hardship to the employer.

No Harassment, Retaliation

The Court also saw no harassment in the fact that her co-workers made remarks about her praying on the job. To be the basis of a lawsuit, offensive treatment by others must be physically threatening or humiliating and substantially interfere with the victim's ability to work. Complaining about something which does not amount to harassment is not the basis for a retaliation complaint. **Stallworth v. Singing River Health, 2011 WL 2532473 (S.D. Miss., June 24, 2011).**

Discrimination: Minority Nurse Awarded Verdict.

An African-American nurse was hired as a nurse manager, then was demoted to the position of senior staff nurse after she reportedly used her management position to speak out about discriminatory practices at the facility.

The jury in the District Court, El Paso County, Texas awarded her $513,000 in damages. That included compensation for lost income as well as injury to her professional reputation, mental anguish and emotional distress.

The lawsuit was premised on two separate violations of state and Federal laws, direct discrimination against her and retaliation against her for opposing discrimination against others.

The jury reportedly heard corroborating testimony from other facility employees that she was treated differently than other managers. **Hollis v. Texas Tech., 2011 WL 2626563 (Dist. Ct. El Paso Co., Texas, May 6, 2011).**

Labor & Delivery: Nurse Gave Oxygen And Pitocin At The Same Time.

A lawsuit filed in the Circuit Court, Kane County, Illinois resulted in court approval of a $5,000,000 settlement from the hospital to be paid into a trust fund on behalf of an infant born with severe cerebral palsy.

Expert witnesses for the family were prepared to testify that the labor and delivery nurse was at fault for seeing the need to start and starting the mother on supplemental oxygen but leaving the Pitocin running at the same time.

The nurse was also faulted for delay in reporting signs of fetal distress that, if reported promptly, would have resulting in the cesarean being done sooner, in the experts' opinions. **Betancourt v. Rush System, 2011 WL 2489019 (Cir. Ct. Kane Co., Illinois, March 17, 2011).**

Stolen Epidural: Jury Finds No Negligence.

While the patient was in labor a physicians assistant who had been newly hired at the hospital came into the room and stole her epidural pump.

He was eventually prosecuted for the crime, placed on probation and stripped of his physicians assistant credentials. He insisted he did it in order to use the pain medication to treat his dog.

The patient sued the hospital for negligent infliction of emotional distress. She had to wait while another pump was installed and was questioned by hospital security personnel in her hospital bed.

The hospital pointed out the physicians assistant's employment references were contacted and a standard background check was done before he was hired and nothing turned up raising a red flag he had criminal tendencies.

The jury in the Superior Court, Stamford-Norwalk County, Connecticut agreed that the hospital had fulfilled the full extent of its legal responsibilities and was not negligent for failing to anticipate and prevent what happened. **Loglisci v. Stamford Hosp., 2011 WL 2432784 (Sup. Ct. Stamford Co., Connecticut, April 27, 2011).**

Spider Bite: Family Of Nursing Home Patient Sues.

An elderly nursing home patient died after being bitten by a brown recluse spider at the facility. The family sued.

The Supreme Court of Texas pointed out that state regulations in Texas as in other states and Federal standards require a nursing home to maintain a safe, sanitary and comfortable environment and to have a regular pest-control program.

That being said, the family's lawsuit was dismissed because the Court determined it was a health-care liability case for which an expert's opinion on the standard of care was a mandatory prerequisite to filing suit. **Omaha Healthcare v. Johnson, __ S.W. 3d __, 2011 WL 2586851 (Tex., July 1, 2011).**

Dysphagia: Family Cannot Prove Negligence Was Cause Of Death.

The ninety-four year-old patient was brought to the E.R. for what was described as alteration in mental status.

She was already in very poor health with long-standing medical diagnoses of dementia and dysphagia. The patient's son had declined the feeding tube which the physicians had recommended and, after having been trained to do so, had been feeding his mother himself at home.

The diagnosis in the E.R. was a urinary tract infection and she was admitted for treatment.

While being fed lunch by a nurse the patient became unresponsive. She was revived, but after discussions with the son and his brother, the physicians elected not to provide further heroic measures and she passed away later that evening.

The Court is not persuaded to depart from the established rule that proof in a medical negligence case requires expert testimony.

SUPREME COURT OF RHODE ISLAND
June 24, 2011

The Supreme Court of Rhode Island would not allow the case to go forward without expert testimony that the nurse was guilty of negligence.

It cannot be assumed from the mere fact that the patient expired while a nurse was feeding her that the nurse did not take appropriate precautions for feeding a patient with known histories of dysphagia and dementia. Even if the patient did experience respiratory failure it was not necessarily caused by aspiration of her food.

The son had declined the offer of an autopsy and his experts were not allowed to testify because they were not available for pre-trial depositions, but it was only speculation whether the autopsy or the experts' testimony would have helped his case. **Manilou v. Miriam Hosp., __ A. 3d __, 2011 WL 2517231 (R.I., June 24, 2011).**

Brain Bleed: Nurse In E.R. Provided Competent Care.

The twenty-one year-old patient came to the hospital's emergency department at 4:40 p.m. with what she described as the worst headache of her life.

She told the E.R. physician the headache started when she landed after jumping out of a tree, about a three-foot drop. In addition to the left-side headache she told the physician she had dizziness, difficulty with light, right-sided clumsiness and weakness in her right arm.

The E.R. physician had a CT scan done at 5:15 p.m. which was reported to him as negative at 5:42 p.m.

The E.R. nurse continued to watch her patient closely. At 6:26 p.m. her face was drooping and four minutes later she fell into a deep sleep. The nurse started O_2 and within a few minutes was on the phone with the on-call neurologist, who was not able to come to the hospital at that moment.

The nurse got the neurologist to come in two hours later. He diagnosed a dissected carotid artery which caused a blood clot and a stroke.

DISTRICT COURT
LARIMER COUNTY, COLORADO
February 11, 2011

The jury in the District Court, Larimer County, Colorado found no negligence by the physicians or nurses who cared for the patient, despite the negative outcome.

The care provided to the patient met the standard of care. With hindsight it could be alleged that a scan which included the neck as well as the head might have pinned down the problem earlier, but the physicians were not to blame. **Wheeler v. Banner Health, 2011 WL 2580871 (Dist. Ct. Larimer Co., Colorado, February 11, 2011).**

Hospital Bed: Footboard Comes Loose, Visitor Falls, No Liability.

A ninety year old family member was visiting his wife in her hospital room.

While he was sitting in a chair at the foot of the hospital bed he decided to stand up and go pick up a pillow that had fallen on the floor.

He grabbed the footboard of the hospital bed to steady himself as he tried to stand. The footboard came loose from the bed and he fell to the floor.

The man fractured his hip in the fall, a painful and disabling injury which required considerable time in a nursing facility for his rehabilitation.

The mere fact that the footboard became detached from the hospital bed does not establish negligence on the part of the hospital.

COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
January 14, 2011

In his lawsuit against the hospital the jury in the Court of Common Pleas, Cuyahoga County, Ohio found no negligence by the hospital and awarded no damages for the man's injuries

The lawsuit claimed that hospital employees who changed the linens on the bed daily or more frequently detached the footboard or knew it was detached and failed to reattach it and/or failed to warn the family member that the footboard was not attached to the bed.

In general terms the law imposes a duty on the owner of a commercial establishment to warn patrons of a dangerous condition on the premises that the patron is not aware of or would not normally become aware of.

The hospital claimed in its defense that there was nothing negligent in the way the bed was maintained and the fact that the footboard is supposed to come loose when manual pressure was applied to it does not add up to negligence. **Karban v. Univ. Hosp., 2011 WL 2732462 (Ct. Comm. Pl. Cuyahoga Co., Ohio, January 14, 2011).**

Fall: Was Patient Being Helped To The Commode?

The jury had to decide which version of the events to believe.

It was undisputed the patient somehow sustained a patellar dislocation at some point after knee replacement surgery that was followed by nine more surgeries and eventual removal of the patella leaving the patient permanently disabled.

The question was, how did it happen?

The patient and her family claimed there were two incidents, both of which pointed to negligence by the hospital staff. According to them she was being helped onto the commode by a single staff member when the high seat, not clamped down to the commode, gave way and she fell, and another time she was dropped during a transfer.

The hospital could only say that the nurses on duty had no recollection of either incident, did not chart them and did not fill out incident reports. An orthopedic expert testified that dislocation of the patella is a possible and sometimes unavoidable complication during necessary post-operative ambulation of the patient.

It would be negligence to fail to secure the high seat to the commode for use by a morbidly obese patient who is recovering from knee replacement surgery.

SUPREME COURT OF LOUISIANA
July 1, 2011

The Supreme Court of Louisiana believed the jury was led by inconsistencies in their testimony not to believe the patient or the family. The jury is the final authority on the credibility of the witnesses.

The standard of care does require special precautions such as two person assist in transfers for a morbidly obese patient following total knee replacement and attention to the fact that the high seat must be properly secured to the commode, but that was not how it happened. **McGothlin v. Christus St. Patrick Hosp., __ So. 3d __, 2011 WL 2586853 (La., July 1, 2011).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Psychiatric Patient Tased: Hospital Can Be Liable.

The patient who admitted himself was diagnosed with paranoid schizophrenia, bipolar disorder, delusions and other mental illnesses.

When he became agitated he was given medication pursuant to the physician's orders, but he still did not calm down. Several hospital staff together tried unsuccessfully to place him in restraints. Then hospital security was called.

Hospital security officers subdued the patient in the hallway by three times using a Taser. Then they helped put him in four-point restraints. He soon became unresponsive and died.

The warning label on the Taser cautioned against its use on a physiologically or metabolically compromised individual. The US District Court for the Southern Division of Ohio pointed out that warning would apply to a person on heavy doses of medication to control psychotic agitation. The Court questioned the decision of the psych unit nurse manager to bring in hospital security to subdue this patient even though that actually was allowed by the hospital's policies. **Brinson v. Univ. Hosp., 2011 WL 2492960 (S.D. Ohio, June 22, 2011).**

Psychiatric Patient Assaulted: Aides' Firings Upheld.

Two psychiatric aides were fired after a physical altercation with a patient. The Superior Court of New Jersey, Appellate Division, ruled the facility had grounds to fire them.

The problem started when the night-shift aides were not able to convince the patient to get out of bed at 6:00 a.m. Unit policy for this situation was to allow a patient to stay in bed and let the day shift try to wake the patient 7:00 a.m.

Hospital policy also required an aide to back away from any physical altercation with a patient and, when a patient acted out, to report to the nurse and obtain guidance rather than going ahead on the aide's own initiative. The rationale was to favor de-escalation over confrontation as a treatment tool and to protect patient safety.

Aides were allowed to defend themselves physically, but only as a last resort when retreat was not possible. The patient apparently did lash out when the aides would not leave him alone, but failing to report to the nurse, engaging and then retaliating against the patient was wholly inappropriate, the Court said. **Matter of Okafor, 2011 WL 2535158 (N.J. App., June 15, 2011).**

E.R.: Nurses Found Negligent But No Proof They Were Responsible For The Patient's Injuries.

The E.R. physician diagnosed the patient with a tension headache or possibly a migraine and sent him home.

The next day when she got home from work the patient's wife found him vomiting and unable to walk. She phoned an ambulance which took him to a different hospital where he was diagnosed with a cerebral hemorrhage.

The patient had several surgeries with post-surgical complications. He is now brain-injured and blind.

The patient's settlement with the hospital was for $1,000,000 plus the right to sue the E.R. physician's practice group for $1,000,000 more than the $3,000,000 which it already paid by way of settlement of the claim which was valued at $5,000,000. The E.R. physician defended that lawsuit by arguing the E.R. nurses were to blame.

It was a critical piece of information that the patient was referred to the emergency room by his own personal physician for his persistent headaches accompanied by vomiting,

He did not come to the E.R. on his own just because he had a headache.

He should not have been placed in the waiting room for minor ailments and left there two hours.

NEW YORK SUPREME COURT
APPELLATE DIVISION
June 30, 2011

The New York Supreme Court, Appellate Division, believed the E.R. nurses were negligent. A nursing expert opined that the E.R. nurses improperly placed the patient in a waiting room for those with only minor injuries.

In addition, critical information, that the patient was sent to the E.R. by his own physician and did not come in on his own, was nowhere to be found in the nurse's triage note and was not conveyed to the E.R. physician before he misdiagnosed it as a simple headache.

However, there was no evidence the E.R. physician would have ordered a CT and correctly diagnosed the patient if he had been told how the patient got there, the Court said, expert testimony on all aspects being necessary in a malpractice case. **Caruso v. Northeast Emergency Medical, __ N.Y.S.2d __, 2011 WL 2568466 (N.Y. App., June 30, 2011).**