Jail Nursing: No Deliberate Indifference.

The patient was picked up and taken to the county jail by a detective for allegedly failing to send in his monthly report form to his probation officer.

The day after he was booked into the jail he came to the dispensary requesting medical attention for chest pains. He asked for Norco (hydrocodone) and Xanax. The nurse took his vital signs and gave him two .4 mg nitroglycerine tablets. After five minutes he said his chest pain was gone, so the nurse sent him back to his cell with additional sublingual tablets.

The next day another inmate got a guard to escort the man to the infirmary. He said his chest pain was radiating into his left arm and the nitroglycerine was not working. The nurse called the physician who ordered an EKG. The EKG was not definitive so he was transferred to a nearby university hospital for further evaluation.

The nurses properly screened and evaluated the patient when he was booked into the jail and cared for him appropriately on two later occasions.

The fact the patient was given different medication than he requested does not amount to deliberate indifference to an inmate's serious medical needs.

UNITED STATES DISTRICT COURT
CALIFORNIA
June 6, 2012

The US District Court for the Eastern District of California dismissed the inmate's lawsuit. His care was appropriate in all respects.

A nurse checked his vital signs and gave him nitroglycerine, which seemed to alleviate his symptoms, then when his symptoms persisted they contacted the physician, got an EKG and had him transferred out for a more complete evaluation. **Quinn v. Fresno Co., 2012 WL 2052162 (E.D. Cal., June 6, 2012).**

Repeated Falls: No Review Or Modification Of The Care Plan.

State nursing-facility regulations require residents to be provided with nursing services in accordance with their needs which must include:

Development of a written plan of care for each resident to provide nursing services as part of the total rehabilitation program;

Periodic reevaluation of the type, extent and quality of services and programming; and

Modification of the resident care plan as needed, in terms of the resident's daily needs.

Failure to notify the consulting RN of the patient's repeated falls, and the resultant failure of the RN to investigate them mounts to failure of the facility to provide the resident with nursing services in accordance with her needs.

The facility had an adequate initial care plan for this resident, but it was not updated as necessary to address her problem with falling which was becoming a pattern with her.

The facility failed to provide adequate care and that failure directly resulted in injury to the resident. The penalties and other sanctions were appropriate.

APPELLATE COURT OF ILLINOIS
June 12, 2012

A sixty-three year-old woman with diagnoses of Down syndrome, Alzheimer's disease and osteoporosis was a resident of an intermediate care center for developmentally-disabled adults. Her cognitive level was that of a twenty-three month-old child.

Over a four-month period she fell in the facility at least eleven times, sustaining various bruises, hematomas and abrasions.

A complaint led to an investigation which resulted in citations for violations of the state's Nursing Home Care Act as well as the facility's operating license being placed on probationary status. The Appellate Court of Illinois upheld the penalties and other sanctions imposed on the facility.

Facility Staff Ignored Internal Policies Designed to Trigger Care Plan Update

In accordance with state law, the facility had a policy which required staff on duty when a resident sustained an injury to make observations and take appropriate action to obtain basic information necessary for nurses and physicians to make further clinical judgments and notify the house manager or administrator so that the house manager or administrator could, in turn, notify the nursing staff.

On numerous occasions the resident was seen falling or found on the floor or in between items of furniture. Her vital signs were taken and/or she was visually looked over, but no one else was notified so that a medical evaluation could be obtained.

Further, when a resident falls repeatedly it is necessary, pursuant to state regulations, for the multidisciplinary quality assurance committee at its regular meetings to review the patient's medical, nursing, medication and pharmacy records with a view toward making appropriate modifications of the care plan.

In addition, bruising found on a patient's body on an ongoing basis is an incident which must be reported to the Department of Public Health. The occurrence of repeated injury from falling can be considered abuse or neglect, which is a violation of nursing facility standards itself and the failure to report abuse or neglect is a separate violation, the Court said. **UDI No. 2 v. Dept. of Public Health, __ N.E. 2d __, 2012 WL 2108491 (Ill. App., June 12, 2012).**