Choking Death: Court Allows In Legally Damaging Statements Of Facility Employees.

The elderly patient had lifetime difficulties with swallowing since polio as a youth left her throat partially paralyzed.

When she developed Alzheimer's and entered long-term care she was put on a soft diet and her care plan called for close supervision while she was eating.

While not actually being watched in the dining room she became unresponsive. A CNA noticed the problem and called a nurse who swept the mouth, found nothing, started CPR and called an ambulance to take her to the hospital where coleslaw was suctioned from her throat before she died.

CNA's Hearsay Statement Admissible As Evidence Against The Nursing Facility

The trial boiled down to a battle of the experts' conflicting interpretations of the complex medical evidence.

The family's expert testified the patient choked on her food, started having a cardiac arrhythmia as a result and died from cardiac arrest from the arrhythmia.

The jury, however, believed the nursing facility's expert who testified that the patient's age, medical condition and her Alzheimer's medications predisposed her to a heart arrhythmia which led to a fatal cardiac event while she happened to be eating and had food in her mouth, which would have happened anyway even if someone was watching her.

The District Court of Appeal of Florida overturned the jury's verdict and ordered a new trial because the trial judge erroneously refused to let the jury hear a hearsay statement from a kitchen helper that a CNA had said that a patient had choked in the dining room.

The kitchen worker and the CNA were both nursing home employees and, as such, the family had the right to bring their damaging statements to the jury's attention even though the testimony was hearsay and clearly was not based on any medical evidence the CNA was competent to judge.

The Court justified its ruling to allow the jury in the new trial to hear what the CNA had to say by pointing to a line of cases that generously allow caregivers' admissions of liability in healthcare cases.

The trial boiled down to a battle of the experts.

The patient's family's medical expert claimed the elderly patient choked on her food, suffered cardiac arrest as a result and died.

The nursing facility's medical expert claimed the patient suffered an arrhythmia which led to cardiac arrest which happened to occur while she was eating.

DISTRICT COURT OF APPEAL
OF FLORIDA
June 27, 2012

In these cases the remarks voiced by healthcare facility employees were allowed to come to the jury's attention even though they were not experts and their remarks begged very complicated technical questions bearing on the complex legal liability issues presented in the cases.

In one case the jury was allowed to hear testimony from one nurse that another nurse said that a patient fell because someone had spilled milk on the floor and it was mopped up after the fall.

In another case someone was allowed to testify a hospital employee had admitted there was too much wax on the floor after a visitor slipped and fell.

In still another case one nurse was allowed to testify that another nurse told her that she had found the patient on the floor wearing her Posey vest while the bed rail was still up, leading to the conclusion that the vest had not been secured to the bed as it should have been to prevent the patient from getting up.

The cases point out the potentially damaging legal consequences of caregivers freely voicing their own personal opinions after an incident occurs in the workplace involving potential legal liability. **Benjamin v. Tandem Healthcare, __ So. 3d __, 2012 2400880 (Fla. App., June 27, 2012).**

Hearing Impaired Nurse: Reasonable Accommodation Is Required.

It came to her supervisors' attention that a registered nurse working in the Alzheimer's unit of a long-term care facility was seriously hearing impaired.

It was not clear whether she had the problem when she was hired more than five years earlier or if it had developed over time while she was working there.

After she did not respond to an alarm a supervisor "tested" her hearing by standing behind her and talking. After she failed the test she was fired for inability fulfill her nursing position's essential functions.

It would not be an unreasonable accommodation to provide an amplified stethoscope, tell the CNA to carry the walkie-talkie and tell the CNA's to alert the nurse to any alarms or pages and to advise staff and families to speak to the nurse face-to-face so that she can lip read what they are saying.

MISSOURI COURT OF APPEALS
July 17, 2012

The Missouri Court of Appeals ruled that the nurse was entitled to reinstatement to her position with back pay for the time she missed. The facility was guilty of violating the Americans With Disabilities Act as well as the state disability discrimination regulations that applied to the nurse's civil service position.

The nurse was not able to fulfill the essential functions of her position without reasonable accommodation, but that is not the relevant question. There were a number of not-unreasonable measures the facility could have taken but which were never put on the table to allow the nurse to continue to work with due regard for patients' safety and wellbeing, the Court said. **Missouri Vets Home v. Brown, __ S.W. 3d __, 2012 WL 2891103 (Mo. App., July 17, 2012).**

Choking Death: Court Reviews Psych Patient's Caregivers' Actions, Dismisses Family's Lawsuit.

The adult patient was involuntarily admitted to a state psychiatric hospital with a diagnosis of schizoaffective disorder, bipolar type.

A staff physician at the psychiatric hospital designated her as a high risk for choking on her food and ordered a pureed diet and arms-length supervision whenever she ate anything.

One day when the snack cart was going around the building where she was housed someone gave the patient a candy bar from the cart. She choked on the candy bar, suffered anoxic brain injury and passed away one week after the incident.

The US District Court for the District of New Jersey was highly critical of the fact the patient was allowed to have a candy bar in the first place, the processes that led to the choice of the non-licensed staff member who was supposed to have been watching her and the nurses' response as the incident transpired.

However, for technical legal reasons the Court dismissed the family's lawsuit against the State of New Jersey and the individual care giving employees involved. The lawsuit alleged violation of the patient's Constitutional rights through deliberate indifference to her medical needs, which is very difficult to prove.

The patient was an involuntarily detained psychiatric patient in a state facility. An involuntary patient is basically a prisoner whose Constitutional rights are violated only if there is deliberate indifference so blatant that it shocks the court's conscience.

UNITED STATES DISTRICT COURT
NEW JERSEY
June 22, 2012

Medication Nurse

The surveillance camera caught the incident on tape. The patient took several sips from a beverage in her hand and then sat down on the floor and began eating something. Then she struggled to her feet, fell back to the floor and slumped over.

Alerted by another patient that there was a patient on the floor turning blue, the medication nurse on duty came into the picture but just as quickly left the patient on the floor and was out of the picture.

The medication nurse went to the nurses station to call a code to alert other personnel and then went for the crash cart, kept about 50 or 60 feet away.

The established procedure for an unconscious patient required the nurse first-responder to stay with the patient and start CPR. The medication nurse was written up for failing to follow the procedure.

The Court, however, ruled that the medication nurse was not guilty of abandoning her patient in a critical time of need as alleged in the family's lawsuit.

She apparently believed that she as the medication nurse had the responsibility in an emergency to alert other nurses, get the crash cart and make herself available to assist the charge nurse. In any case, the Court said, she did not have "the luxury of proceeding in a deliberate fashion" under the circumstances.

Charge Nurse

The incident occurred while the staff nurse assigned to the patient was on break.

The charge nurse assigned in the interim a non-licensed individual to monitor the patient but apparently failed to communicate with him about the fact that strictly controlling her food intake and closely watching her one-on-one when she ate applied not only in the dining room during meal times but also any time any food became available to her.

The Court believed this failure to communicate was negligence on the part of the charge nurse, but it was not serious enough to amount to deliberate indifference and, therefore, was not a violation of the patient's Constitutional rights.

It was also alleged that the staff member in question was unreliable and the charge nurse should not have delegated to him the task of monitoring a patient with special needs for whom a lapse in monitoring could have very dire consequences. **Marcucci v. Ancora Psychiatric Hosp., 2012 WL 2374653 (D. N.J., June 22, 2012).**

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

More legal Information for nurses is available at Legal Eagle Eye Newsletter for the Nursing Profession Home Page.