LEGAL EAGLE EYE NEWSLETTER

December 2005 *For the Nursing Profession* Volume 13 Number 12

Duty To Assess, Report, Advocate: Patient's Death Tied To Negligent Nursing Care.

The seventy-five year-old patient came to the emergency room with a headache and right-arm weakness.

An order was written to admit her to the neurological care unit but she was not actually taken there until three hours later. A call placed to one physician was returned by another 1 1/2 hours after that. He ordered meds for blood pressure and nausea. Three hours after that the nurses called a physician to report neuro changes and elevated blood pressure. The physician ordered an emergency CT scan which revealed a massive brain hemorrhage.

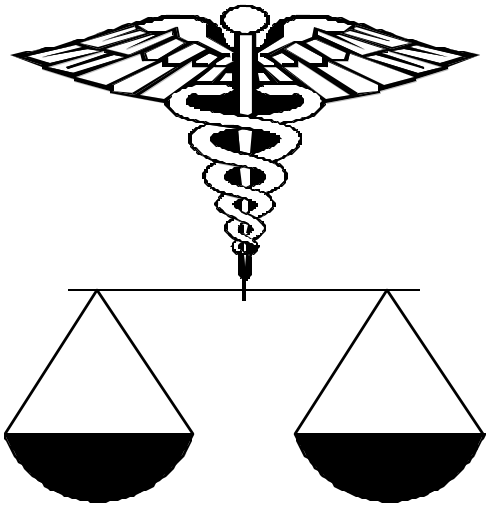
The patient had surgery within three hours but did not recover. She was taken to a hospice and died.

Statement of Legal Standard of Care

The Court of Appeals of Texas ruled that the medical expert retained by the family's attorneys correctly stated the legal standard of care for nurses in this situation and stated how the nurses' negligence in departing from the standard of care was the legal cause of the patient's death.

Delay in Transfer to Neuro ICU

When a patient with acute neurological process is ordered admitted to an intensive care setting, that transfer cannot be delayed. Delay in transfer can mean critical delay in treatment.



Cerebral hemorrhage requires prompt medical intervention.

The nurses must correctly assess the patient's changing neurological status.

Failure of the nurses to advocated for their patient, that is to insist upon prompt medical evaluation, including a brain CT scan, can delay proper diagnosis and treatment.

COURT OF APPEALS OF TEXAS
November 16, 2005

Nurses' Duty to Advocate For Patient

Nurses must monitor their patients competently and must promptly and effectively communicate changes in status to the physician.

The court faulted the nurses because they, "... meekly accepted inadequate responses of Dr. ... and Dr. ... with no further calls to physicians until the patient was *in extremis.*"

A physician who is not actually present has no way to appreciate the magnitude of the downward neurological changes a patient is experiencing unless the nurses fully communicate it and insist upon prompt evaluation of the patient's changing status.

Cause and Effect

The court accepted the family's medical expert's conclusion that this patient's death would have been avoided with proper management of her case by the hospital's nurses.

A bleeding lesion in the brain requires prompt cessation of the Coumadin the patient is taking, fresh frozen plasma to reverse the Coumadin and a prompt brain CT to locate and evaluate the lesion for medical treatment. Delay in this life-saving treatment was linked directly to inadequate nursing care. **Tovar v. Methodist Healthcare, __ S.W. 3d __, 2005 WL 3079074 (Tex. App., November 16, 2005).**

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Post-Op Instructions: Nurse's Negligence Not Linked To Complications.

The patient underwent an outpatient vitrectomy scleral buckle for a detached retina. The physician's post-operative orders stated, "... position: anything but flat on back."

The patient stayed in a hotel in the city that night to be close to the clinic for her next-day follow-up appointment. She lay on her back while she slept. The silicone oil from her procedure migrated to the front part of her eye. Elevated intraocular pressure required her procedure to be re-done the next day.

The patient sued the outpatient clinic, claiming the nurse was negligent not to instruct her that she was not to lie on her back per the physician's orders.

Giving an opinion on the cause of post-surgical complications equates to making a medical diagnosis.

A nurse who is fully qualified to give an expert opinion on the nursing standard of care nevertheless cannot make a medical diagnosis and cannot render a medical opinion in court.

COURT OF APPEALS OF TEXAS
November 4, 2005

The Court of Appeals of Texas dismissed the case. It is negligent, that is, below the nursing standard of care for a nurse not to communicate the physician's discharge instructions. However, the patient had no medical testimony linking the negligence to her complications. **Kincaid v. Austin Center for Outpatient Surgery, 2005 WL 2978602 (Tex. App., November 4, 2005).**

Substandard Nursing Care: Court Upholds Penalties Imposed On Rehab Facility.

The US Circuit Court of Appeals for the Sixth Circuit has upheld civil monetary penalties imposed on a rehab facility for violations of Federal Medicare participation standards.

The facility had filed an appeal with the court to argue, as it has the right, that the violations imposed by state inspectors were not justified by the evidence.

Personal Privacy

A state surveyor observed that a patient was left uncovered during personal care while the door was open to the room, allowing other residents visual access.

The court ruled this violates 42 CFR § 483.10(e) which says that, *" ... the resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes ... personal care."*

The court said the gist of the violation was not that the resident was uncovered but simply that the door to the room should have been closed.

Call Light

Inspectors observed one particular resident's call light lying on the floor where he could not reach it, five times in two days. The resident needed assistance to walk and his care plan called for a call light so he could ask for assistance.

The court ruled this violates 42 CFR § 483.15(e)(1) which says that, *"... a resident has the right to ... reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered."*

According to the court, it is not a violation of Federal regulations for a resident's call light button to be out of reach on an isolated occasion. The gist of this violation was the fact the call light was observed to be out of the resident's reach and thus unavailable to him on multiple occasions over a two-day period.

Frayed Leg Brace

State survey inspectors found that the canvas cover on a resident's leg brace was frayed to the point that the metal bars were rubbing against her leg and causing sores. In addition, her care plan failed to address the issue whether the leg brace had to be used while she was in bed. Staff also had not been fully trained, in the inspector's judgment, how to place this resident on a shower bed without hurting her.

The court ruled this violates 42 CFR § 483.25 which says that, *" ... each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care."*

Supervision of High Fall-Risk Patients

The court upheld the surveyor's judgment that the facility was not providing adequate supervision and assistance to three specified high fall-risk patients. The court record did not elaborate further.

The court ruled this violates 42 CFR § 483.25(h)(2) which says that, *" ... the facility must ensure that ... each resident receives adequate supervision and assistance devices to prevent accidents."*

The courts have ruled in general terms that a facility is not required to do everything in its power to prevent accidents – a misinterpretation of the regulations – but must take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his or her assessed needs and to mitigate foreseeable risks of harm from accidents.

Shower Bed

The court also ruled that placing a resident on a shower bed with her head at the wrong end deprives a patient of personal dignity and amounts to a violation of Federal standards. **Ivy Woods Healthcare and Rehabilitation Center v. Thompson, 2005 WL 2660425 (6th Cir., October 19, 2005).**

Patient Falls: Court Agrees With Jury That Rehab Hospital's Nursing Staff Were Not Negligent.

A patient sued a rehabilitation facility. Her lawsuit contained complex allegations of medical malpractice by the facility's physicians.

The lawsuit also claimed the facility's nurses' aides were negligent and thus responsible for a femur fracture the patient claimed was caused by a fall in her room.

The Court of Appeal of Louisiana carefully reviewed the records of the patient's care and upheld the jury's verdict that there were no grounds for a lawsuit against the facility.

Fall Risk Assessment

The eighty-two year-old patient was admitted for debility and weakness suggesting she had had a recent stroke.

The nurses placed her in a room four doors down from the nursing station, the closest room available at the time.

The nursing assessment was that the patient was alert and oriented. Before she fell she had demonstrated to the nurses that she could and would use her call bell to ask for assistance to ambulate.

The court said this was not a confused patient who required constant attention from a sitter or family members in her room, as alleged in the lawsuit.

The facility's policy was correct that a patient who has fallen and has a limb in an unnatural position or a painful area should remain undisturbed until a physician is summoned.

However, in this case the patient's left leg, in which the femur fracture was diagnosed six days later, was straight out in front of her; it was not in an unnatural position.

The nurse who straightened her right leg documented she asked the patient and the patient reported no pain in either knee or leg.

There is no indication the patient was injured from being eased to the floor.

For six more days the patient had exercises in physical therapy for the left knee that was already swollen on admission, which is inconsistent with a fresh femur fracture.

COURT OF APPEAL OF LOUISIANA
October 26, 2005

Circumstances of the Fall

The patient was being assisted to the bathroom by two aides. It was true, as alleged in the lawsuit, that one of the aides was seven months pregnant, but the court noted that was why there were two aides.

When the patient's legs gave out, the aide directly behind the patient eased the patient gently the floor as she had been trained. The other aide went for a nurse before the aides tried to move or even reposition the patient on the floor.

The court said the aides' actions were completely within the standard of care. The court discounted the allegation that a transfer belt should have been in use as even if a transfer belt were in use it would not have made any difference.

Post Fall Assessment / Documentation

The nurses who came to help the patient documented in the nursing notes that the patient's left leg was straight out in front of her and her right leg was bent at the knee before the nurses straightened her leg so she could lie back on the floor. No pain was evident as the nurses straightened her leg and moved her back to bed.

According to the court, a patient with a fresh femur fracture would obviously be having intense pain. A deformity of the femur would perhaps be apparent from gross visual observation.

Nursing facilities have an obligation to notify the physician of any change in a patient's health status, including injuries from a fall, but the court said that begs the question whether the patient was actually injured. **Murphy v. Bernice Community Rehab Hosp., __ So. 2d __, 2005 WL 2757511 (La. App., October 26, 2005).**

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Nursing Notes: Nurses Should Not Give Medical Opinions.

The patient received a blood transfusion during knee replacement surgery.

Soon he experienced chills, wheezing, headaches, shortness of breath and anxiety, signs and symptoms which could have indicated an adverse reaction was occurring to the transfusion.

Eleven months later he was hospitalized for pneumonia and died. His widow sued the first hospital for negligence for administering mismatched blood and for the nurses not monitoring him for signs and symptoms of a reaction afterward.

A hospital's nursing notes are considered business records and as such are routinely admitted into evidence in negligence cases.

However, a statement of opinion in a business record is not admissible as evidence unless the person who recorded the opinion is qualified to do so.

APPELLATE COURT OF CONNECTICUT
October 18, 2005

The Appellate Court of Connecticut opted for dismissal of the case.

The widow's attorneys tried to base the case on a nursing note from the second hospital, written in cryptic hospital abbreviation jargon, that the patient had a history of pulmonary signs and symptoms that was secondary to a transfusion reaction at the first hospital.

The court ruled that a medical opinion contained in nursing notes written by someone who does not have the medical credentials to render an opinion will not support a malpractice case. **Cavallaro v. Hospital of Saint Raphael, 882 A. 2d 1254 (Conn. App., October 18, 2005).**

Nursing Notes: Patient Fell, But Did Not Dehisce Surgical Wound.

The patient was in the hospital recovering from open-heart triple-bypass surgery when his nurse assisted him to the bathroom.

He fell while being assisted back to bed. After that the surgical site in his chest dehisced and a post-operative infection set in. He had to go back to surgery for revision of the surgical sutures.

He sued the hospital for the nurse's negligence related to his fall.

Based on the nursing documentation, a reasonable jury could see a violation of nursing standards, and at the same time rule that the violation did not cause the dehiscence.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
November 1, 2005

The Superior Court of New Jersey, Appellate Division, agreed with the jury that the nurse was negligent for ignoring physician's orders for him to stay in bed.

However, the nurse's notes candidly admitted that the fall happened and carefully described how it happened, that is, that he only dropped to his knees.

Thus the jury had good reason to believe, based on the way the nurse had documented the fall in the nursing notes, that the fall did not cause any trauma to his chest to explain the dehiscence of his surgical wound. The nurse's and doctors' physical assessments shortly after the fall also did not find any chest trauma.

The court said dehiscence and infections are unfortunate but common post-operative occurrences which are not necessarily linked to a healthcare provider's negligence. **McKinless v. Francis, 2005 WL 2850067 (N.J. App., November 1, 2005).**

Diabetes Care: Court Says Prisoner's Rights Were Not Violated.

A prisoner in a state prison sued two nurses, the prison doctor, the warden and two prison guards alleging substandard health care.

The prisoner told his nurses he believed he was supposed to have daily finger sticks to monitor his blood sugar levels. The nurses refused to do finger sticks because they had no physician's order.

The nurses, however, did contact the doctor because the prisoner was reporting headaches, a possible symptom his blood sugar levels were not being managed appropriately by his oral medication.

The doctor decided to discontinue his oral diabetes medication for a few days with the nurses to do daily finger sticks, but the prisoner refused to allow it.

A prisoner's disagreement with his healthcare providers does not imply deliberate indifference.

UNITED STATES DISTRICT COURT
VIRGINIA
October 19, 2005

The US District Court for the Western District of Virginia threw out the prisoner's lawsuit.

In general, a prisoner has the Constitutional right to be free from cruel and unusual punishments. That translates to the right to sue healthcare providers if they have been deliberately indifferent to the prisoner's serious medical needs.

However, the court ruled that deliberate indifference does not occur any time a prisoner disagrees with the course of treatment that prison caregivers have chosen. The court could see nothing wrong with the actions of the nurses or the physician in this case. **Spencer v. Williams, 2005 WL 2671345 (W.D. Va., October 19, 2005).**

Sexual Assault: Court Sees No Liability, Male Nurse Screened Before Hiring.

A patient sued a hospital after a male nurse sexually assaulted her while she was still sedated following a surgical procedure. The lawsuit alleged negligent hiring and supervision.

The hospital countered the lawsuit by showing it had procedures in place for background screening of nurse applicants and that its procedures complied with acceptable hospital practices.

In this case it is pure speculation that a more thorough background check would have revealed a propensity toward sexual misconduct. Speculation will not support a negligence lawsuit.

NEW YORK SUPREME COURT
APPELLATE DIVISION
November 17, 2005

In a short opinion the New York Supreme Court, Appellate Division, did not go into detail on the requirements for background checks on nursing applicants.

However, the court did reaffirm the principle that to sue a healthcare employer over a sexual assault a patient must have actual proof that a background check was not done, or was done deficiently, and that a proper background check would have turned up a prior incident showing a propensity toward sexual misconduct.

The court did rule that a nursing manager who is responsible for assessing nursing credentials is not responsible for background checks or verification of past employment. Those functions can be carried out by a hospital's human resources department. **Travis v. United Health Services Hospitals, __ N.Y.S.2d __, 2005 WL 3073198 (N.Y. App., November 17, 2005).**

Misconduct: Aide Abused Patients.

The Court of Appeals of Minnesota ruled that a nursing home had just cause to terminate an aide for aggravated misconduct, that is, abuse of two vulnerable adults under her care.

Abuse of a patient or resident in a facility providing care for vulnerable adults is aggravated employee misconduct justifying termination for cause.

COURT OF APPEALS OF MINNESOTA
November 1, 2005

Obscene Language Used

Without repeating exactly what was said, the court ruled that yelling an obscenity at a patient is considered disparaging and humiliating treatment, that is, it is within the legal definition of abuse.

Walker Taken Away

In a second incident involving another resident, the aide took away the resident's walker to keep the resident from leaving her room, allegedly because there were insufficient staff available to assist the resident and prevent her from falling.

The resident was found by another aide crawling on the floor. The nurse who documented the incident said the resident was sitting on the floor and scooting like the crab walk.

The court discounted the aide's stated concern for the resident's safety as valid justification for her actions.

Taking away a vulnerable person's walker is considered deprivation, and by law deprivation amounts to abuse, the court ruled.

Either Incident Sufficient By Itself

Although the aide was fired over two incidents of abuse, either one of the incidents alone would have justified her firing, the court ruled. **Grossman v. Martin Luther Manor, 2005 WL 2850491 (Minn. App., November 1, 2005).**

Misconduct: Nurse Abused Patients.

The Court of Appeal of Louisiana ruled that a psychiatric hospital had just cause to terminate a licensed practical nurse for conduct involving two patients that was unprofessional, inappropriate, abusive and neglectful.

Cause exists to terminate a civil service employee when the employee's conduct is detrimental to the efficient and orderly operation the public service entity that employed him or her.

COURT OF APPEALS OF LOUISIANA
November 4, 2005

Asthma Medication Withheld

When a patient asked for her albuterol inhaler, the nurse called her a "fat ass," refused to give her her medication and basically ignored her.

The court noted the inhaler, per the physician's orders, was to be kept by the nurses and given to the patient per the nurse's professional discretion like any other prn medication. The nurse, however, did not do her job, which was to make a professional assessment of the patient's need for the medication and to dispense it as prescribed and as warranted; she just ignored her patient.

Dirty Clothes

The nurse had another patient put her dirty clothes back on after a shower. Then the nurse put on rubber gloves before personally escorting the patient back to her room. Then she took away the patient's clothes and threatened to burn them. The patient was seen walking naked in the hallway. **Brown v. Dept. of Health & Hospitals, __ So. 2d __, 2005 WL 2898059 (La. App., November 4, 2005).**

Decubitus Ulcers, Sepsis: Court Links Patient's Death To Sub-Standard Nursing Care.

The Court of Appeals of Texas noted the patient was known to have colonized methicillin-resistant Staph aureus when he was admitted to a rehab facility following heart bypass surgery.

According to the court, this bacteria is not uncommon in hospital and nursing-home patients and can exist on healthy skin without causing an infection.

With daily physical therapy he made good progress for three weeks in rehab, but then his condition began to worsen and his physician sent him to the hospital. He had two Stage III decubitus ulcers on his back on admission to the hospital. He died of multi-system organ failure secondary to sepsis and septic shock.

The court upheld the jury's verdict in favor of the family in their lawsuit against the rehab facility for negligence.

Substandard Nursing Care

The patient was on Lasix to decrease fluid load after his heart surgery. Lasix is a diuretic which can contribute to dehydration, which can be especially problematic if the patient develops diarrhea.

Because he had a feeding tube and a urinary catheter, the court believed it would have been relatively easy to monitor input and output accurately. Nurses have a basic responsibility to keep their patients nourished and hydrated and to monitor and document whether their patients are adequately nourished and hydrated.

The patient, with diarrhea, would often soil his bed and ring for a nurse but experience delays while he lay in his own waste. That led to skin breakdown. The family saw ulcers starting on his hips, but the court found no documentation of care being given for the ulcers.

The documentation was also lacking that the patient was being repositioned every two hours, as nursing standards would require for a patient with potential for or actual skin breakdown. **HCRA of Texas, Inc. v. Johnston, __ S.W. 3d __, 2005 WL 2897559 (Tex. App., November 3, 2005).**

The court accepts the experts' testimony that decubitus ulcers are preventable if the patient is repositioned every two hours. The nursing standard of care requires such repositioning if the patient is unable to reposition himself.

The patient's nutritional status worsened to the point he was classified as malnourished. Muscle tissue then starts wasting to supply the body's nutritional needs, a metabolic state where skin lesions are not going to heal.

The family saw two ulcers on his back.

The hospital records establish that upon admission for his last hospital stay he had two Stage III necrotic decubitus ulcers that were oozing blood.

The fact these lesions were not noted in the rehab facility's records does not dispute their existence. Instead, it tends to establish a high degree of conscious indifference by the rehab facility's nursing staff to the patient's rights despite awareness of an extreme risk of serious harm.

COURT OF APPEALS OF TEXAS
November 3, 2005

Neglect: Aide Had To Watch Two Patients At The Same Time, Charges Dismissed.

A psychiatric technician was told he was responsible for continuously watching one psychiatric patient housed in an unlocked room who was deemed to be dangerous and was also responsible for making fifteen-minute checks on another patient who was on suicide watch.

The facility was one tech short on the shift. The tech used his own discretion. He decided to watch the dangerous patient continuously and to look out the door toward the other patient's room every fifteen minutes. He never left the dangerous patient to actually check on the other.

The patient on suicide watch died of a heart attack. The tech was charged and convicted of the criminal offense of willful or culpable negligence causing great bodily harm to a disabled person.

Even if the tech was mistaken in exercising his own judgment, there was no ill motive toward his patients.

DISTRICT COURT OF APPEAL
OF FLORIDA
October 25, 2005

The District Court of Appeal of Florida threw out the conviction and exonerated the tech.

Physically there was no possible way the tech could implement both physician's orders (from the same physician). The tech had no legal authority to change the orders and had no control over the fact the facility was understaffed. There was no proof, only speculation, that a face-to-face fifteen-minute check on the suicide-watch patient would have made any difference. **Jones v. State, __ So. 2d __, 2005 WL 2736542 (Fla. App., October 25, 2005).**

Flu Vaccine: New Vaccine Info Materials From CDC.

The US Centers for Disease Control and Prevention (CDC) has released new vaccine information materials dated 10/20/05 for influenza vaccines.

These new materials supercede previous versions and must be used, that is, given to patients or parents or legal guardians when vaccines are administered, starting no later than January 1, 2006.

Information and copies of all the CDC's current vaccine information statements are available from the CDC's website www.cdc.gov/nip/publications/VIS.

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The new vaccine information materials for trivalent influenza vaccines must be used starting no later than January 1, 2006.

The new flu vaccine information materials are on our website at:

www.nursinglaw.com/liveflu.pdf

www.nursinglaw.com/inactivatedflu.pdf

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Newsletter Available Online.

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Please include your name and postal mailing address for identification.

All subscribers continue to receive a monthly print copy of the newsletter in addition to online access.

Medicare/Medicaid: Regulations Finalized For Posting Of Nurse Staffing Data In Skilled Nursing, Long-Term Care Facilities.

The new regulations take effect December 27, 2005.

On October 28, 2005 the US Centers for Medicare and Medicaid Services (CMS) published the finalized form of its regulations for daily collection and posting of nursing-staffing data in skilled nursing facilities and long-term care facilities.

CMS's 10/28/05 Federal Register announcement explains the history of this development and CMS's rationale for implementing it. CMS states that quality of care will be improved by greater public accountability for maintenance of appropriate levels of nurse staffing.

We have placed CMS's 10/28/05 non-copyrighted nine-page Federal Register announcement on our website at

www.nursinglaw.com/nursestaffing.pdf

The new regulations themselves, reproduced verbatim in the right-hand column, appear at the very end of the CMS announcement.

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CODE OF FEDERAL REGULATIONS
TITLE 42, PART 483
Sec. 483.30 Nursing services.
* * * * *

(e) Nurse staffing information--

(1) Data requirements. The facility must post the following information on a daily basis:

(i) Facility name.

(ii) The current date.

(iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

(A) Registered nurses.

(B) Licensed practical nurses or licensed vocational nurses (as defined under State law).

(C) Certified nurse aides.

(iv) Resident census.

(2) Posting requirements.

(i) The facility must post the nurse staffing data specified in paragraph (e)(1) of this section on a daily basis at the beginning of each shift.

(ii) Data must be posted as follows:

(A) Clear and readable format.

(B) In a prominent place readily accessible to residents and visitors.

(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

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LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Nursing Professionalism: Court Sees Nurse As Independent Contractor, Legal Rights Not Limited By Workers Comp Laws.

A registered nurse signed a contract with the management corporation for two adult group homes for professional services as a consulting nurse.

The nurse was attacked by a resident of one of the homes and filed a civil personal injury lawsuit against the management corporation for negligent supervision.

In general, an employee assaulted on the job by a patron can file for workers compensation, but, as with any other on-the-job injury, cannot sue the employer for negligence. The corporation argued for dismissal of the case on the grounds the nurse was a corporate employee.

The Court of Appeal of Louisiana, however, ruled the nurse was an independent contractor, not a corporate employee, based upon the professional nature of the services she performed. She could sue the corporation. An independent contractor can get workers compensation if he or she has a workers compensation account with a private insurer or the state fund.

No Right of Control

The corporation did not control or have the right to control the manner in which the nurse performed professional services. It could only opt to renew or not renew her contract based upon satisfactory or unsatisfactory performance.

The nurse used only her own discretion in deciding how to respond to health problems residents might have been having. She set her own hours. She had to review the charts monthly and write documentation on each resident, but was on her own when and how to do this. She was not precluded from working elsewhere while her contract was in effect, so long as she fulfilled her task-related responsibilities at the groups homes. She was paid a monthly fee. No state or Federal taxes were withheld from her compensation. The group home was not in the trade or business of providing healthcare services. **Mouton v. We Care Homes, Inc., __ So. 2d __, 2005 WL 2864226 (La. App., November 2, 2005).**

Nurse/Patient Advocate: Physician's Suspension Upheld Based On Nurses' Complaints.

In a complex and lengthy legal opinion, the Court of Appeals of North Carolina upheld the decision of a hospital's executive committee to suspend a physician's staff privileges.

Proceedings were started against the physician after two nurses sent notes to hospital management complaining about substandard practices in the care of two patients.

Living Will, Family's Wishes Ignored

One patient, the eighty year-old grandmother of one of the nurses, was admitted for gangrene of the left foot.

The physician made arrangements for a surgical consult for her foot to be amputated, despite the fact the patient had signed a living will and the family strongly objected.

The nurses' handwritten notes were forwarded to the hospital CEO.

It does not matter whether the nurses had authority under the hospital's bylaws to start disciplinary action against a physician.

It was the hospital CEO who formally initiated the corrective action in this case, and the hospital CEO certainly has the authority to take such action.

COURT OF APPEALS
OF NORTH CAROLINA
October 18, 2005

The hospital executive committee concluded the patient did not have the mental capacity to consent to an amputation. The living will and/or family's wishes should have been followed.

Code Status Not Clarified

A nurse asked the physician to clarify another patient's code status. The physician changed the code status twice, both times without consulting the patient's primary-care physician, then wrote orders which were too confusing for the nurses to follow.

The hospital executive committee agreed with the nurse that a DNR order is not to be changed without consulting the primary physician and that the orders as written were undly vague. **Lohrmann v. Iredell Memorial Hosp., 620 S.E. 2d 258 (N.C. App., October 18, 2005).**