# LEGAL EAGLE EYE NEWSLETTER

December 2006 *For the Nursing Profession* Volume 14 Number 12


## Nasogastric Tube: Feeding Continued While Position Still Being Checked, Patient Dies.

The patient was admitted to the hospital for respiratory problems. A nasogastric tube was inserted to provide nourishment.

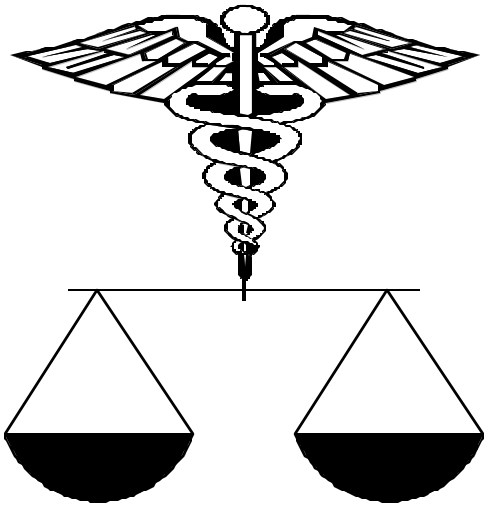
The tube became occluded after some period of use and had to be removed and replaced by the nursing staff. An x-ray was ordered to confirm correct placement.

The x-ray showed it was not correctly placed, that is, it extended down the trachea into the lung rather than down the esophagus into the stomach. The feeding tube was removed and replaced and another x-ray was taken.

While reading of the second x-ray was still pending the nurses resumed infusing nourishment through the tube. In fact, the tube had again been inserted into the lung.

Infusion of nourishment into the lung seriously compounded the patient's respiratory problems and she died.

The Court of Appeals of Arkansas wrestled with legal technicalities involved in continuing the lawsuit against the hospital's corporate parent after the hospital itself had settled with the family for the consequences of the nurses' negligence. **Lee v. Quorum Health Resources, 2006 WL 3222648 (Ark. App., November 8. 2006).**



***The allegations in the patient's family's lawsuit went beyond the negligence of the nurses.***

***The lawsuit also found fault with the communication processes within the hospital between the medical and nursing staff. That would tend to indicate a more widespread problem that a simple error or omission by the nursing staff.***

COURT OF APPEALS OF ARKANSAS
November 8, 2006

## Alzheimer's: Patient Wanders, Adult Day Program Not Liable.

A nursing home's adult day program's Alzheimer's patients were transported to and from their residences in a van owned by a patient-transport company and operated by a company employee.

The contract with the company expressly stated that the patients were never to be left alone unattended.

While the driver was assisting one patient into her home another patient was left alone unattended in the van for a few minutes. He wandered off.

He was found outdoors three days later having suffered severely from hypothermia from which he later died.

The New York Supreme Court, Appellate Division, ruled the nursing home was not responsible. That is, the transport company was fully liable for damages in the family's wrongful-death lawsuit.

According to the court, contracting with a fully licensed independent contractor fulfills a nursing home's legal obligation in this situation. If the driver had been a nursing home employee the nursing home would have been responsible for his negligence. **Chiles v. D & J Service, Inc., __ N.Y. S. 2d __, 2006 WL 3314662 (N.Y. App., November 16, 2006).**

## Inside this month's issue ...

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**New Subscriptions**
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# Narcotics Diversion: Nurse's Behavior Created Reasonable Suspicion, Justified Drug Test.

The US Court of Appeals for the Federal Circuit recently upheld the actions of a med/surg unit nursing manager in a US Veterans Administration hospital who believed a staff LPN's behavior created reasonable suspicion justifying her to demand the LPN to undergo a drug test.

The drug test, legally valid and binding because it followed only upon reasonable suspicion, was positive for morphine and the LPN was fired.

**Suspicious Behavior**

The nurse manager observed all of the following on just one day shift:

The most straightforward evidence of diversion was the LPN's charting of a 4:13 p.m. administration of a dose of a prn narcotic for pain for a patient who had been transferred off the unit at 3:00 p.m.

One of the LPN's patients complained to other nurses that he had asked for pain medication but never got it.

The LPN in question removed oxycodone and lorazepam from the Omnicell for three different patients, but none of the drugs actually being given could be verified by cross-checking the bedside bar code medication administration data or by referencing the patient's individual charts.

The court was not swayed by the LPN's argument that failing to record meds is just sloppy nursing practice, maybe calling for a corrective reprimand. With addictive or habit-forming drugs it is more likely evidence of diversion.

The LPN also apparently used three other nurses' access codes besides his own to get into the Omnicell cabinet.

After his drug test came up positive for morphine the LPN finally did admit to a police detective he had stolen narcotics.

However, if his rights were violated in the first place by requiring a drug test without reasonable suspicion, the whole legal process would have fallen like a house of cards. **Davis v. Dept. of Veterans Affairs, 2006 WL 3251733 (Fed. Cir., November 9, 2006).**

***A supervisor's right to demand a drug test, with reasonable suspicion, comes from governmental regulations affecting public-sector employees or from a collective bargaining agreement with the nurses' union in the private sector.***

***The VA hospital had an established policy that a nurse could be required to take a drug test, but only with reasonable suspicion that the nurse was using or diverting narcotics.***

***A positive drug test is grounds to remove a nurse from his or her position for violating the institution's drug-free workplace policy.***

***If the nurse tests positive for the very same drugs the nurse was suspected of diverting, the case can be turned over to law enforcement for a criminal investigation.***

***The whole process falls apart, however, if the nurse's legal rights are violated at any point. A nurse whose rights were violated in order to prove he or she was diverting narcotics cannot be disciplined and may be able to sue.***

UNITED STATES COURT OF APPEALS
FEDERAL CIRCUIT
November 9, 2006

# Disability Discrimination: Injured Nurse Treated Same As Others For Sedentary Jobs.

A nurse in a hospital's dialysis unit was injured in a non-work-related auto accident and could no longer lift and move patients and move equipment as the hospital required of nurses on the dialysis unit. She had to leave her job.

Her former co-workers kept her informed when physically less demanding positions became available at the hospital such as employee health nurse and utilization review nurse. She inquired of human resources whether these positions were compatible with her physical limitations, was told they were, applied and was interviewed, but other candidates were hired in the end. Another open position, in pre-anesthesia, was not a sedentary position, she was told, and she did not apply.

**No Disability Discrimination**

The US District Court for the Western District of Pennsylvania did not see grounds for the nurse's disability discrimination lawsuit against the hospital.

The hospital was required by law to keep the lines of communication open toward the goal of placing her in a nursing position compatible with her limitations. The hospital did that. The hospital was not required to give her preferential treatment over other applicants. There was no indication the hospital took her inability to do more demanding staff nurse work into consideration in evaluating her suitability for positions which did not carry the same physical demands as staff nurse work.

The nurse herself fully explained to the interviewers she was interested in these particular positions because of her physical limitations. The interviewers could not have unjustifiably suspected her of having limitations she did not have. **Rotolo v. Monongahela Valley Hosp., 2006 WL 2927273 (W.D. Pa., October 11, 2006).**

# Disability Discrimination: Nurse Must Respond To Codes.

According to the US Court of Appeals for the Eleventh Circuit, a nurse's employer has the right to expect a nurse to be physically capable of responding to emergency codes. The employer is permitted by law to define that as an essential function of a nurse's job description.

That is, if being able to participate in codes is necessary in a particular nursing position, and the nurse in question has physical limitations preventing that, the employer does not commit disability discrimination by excluding the nurse from the position.

The court could not apply the concept of reasonable accommodation. The nurse in this case could not explain how her employer could provide an accommodation, an accommodation that would be reasonable and not an undue hardship to the employer, to compensate for her inability to respond to patient emergencies. **Gary v. Dept. of Human Resources, 2006 WL 2946842 (11th Cir., October 17, 2006).**


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# Patient Falls: No Bed Alarm, Court Awards Family $1 Million.

***The quality-assurance incident report was admissible in evidence.***

***That is, after data was redacted from the report that no jury was meant to see, the incident report was properly given to the jury as evidence.***

***The basic facts must be revealed to the jury even if the incident report is the only place the hospital has recorded the date, place, time, names of witnesses, what happened, whether the patient was injured and knew she had fallen and whether restraints, a call bell or bed alarm were in use.***

***The deliberations and conclusions of the quality assurance committee are shielded by law under the privilege of quality assurance confidentiality.***

***The basic facts of what happened are not confidential information.***

SUPREME COURT OF VIRGINIA
November 3, 2006

The seventy-nine year-old patient was admitted to the hospital with profound generalized weakness and new-onset confusion, disorientation, hallucinations, agitation and dehydration. She had been diagnosed with lymphoma ten years earlier.

The hospital's admission form was designed to prompt the nurses to check off a set of factors to assess the patient for fall risk. This patient, however, was not identified as a fall risk and no fall prevention measures were started for her.

A staff nurse raised only the top bed rails, put a call bell within the patient's reach and verbally instructed the patient not to get out of bed by herself but instead to use her call bell to ask for help getting out of bed.

The patient fell and broke her hip in the hallway just outside her room. After she died six months later from her lymphoma the family sued for her fall injury and got a $1,000,000 verdict which was upheld by the Supreme Court of Virginia.

The court accepted the testimony of a nurse who testified as an expert witness for the family that the patient should have been identified as a high fall risk.

Her fall-prevention plan, in the nurse/expert's judgment, should have included restraints or, better, a bed alarm which would have alerted the nursing staff if she got out of bed. There also needed to be a reliable system for nurses or other staff to respond promptly to the alarm going off indicating the patient was trying to get out of bed unassisted. **Riverside Hosp., Inc. v. Johnson, __ S.E. 2d __, 2006 WL 3106157 (Va., November 3, 2006).**

# Skilled Nursing Care: Court Sees Substandard Practices With Restraints, Skin Care, Incontinence Care, Upholds Penalties.

The US Court of Appeals for the Sixth Circuit recently upheld a total of $83,100 in civil monetary penalties imposed on a Medicare-participating skilled nursing facility by state survey inspectors for multiple violations of Federal standards for nursing facilities.

A nursing facility has the right to appeal at two levels within the US Department of Health and Services and then can appeal to the US Court of Appeals.

However, the US Court of Appeals pointed out that in these cases the court usually believes what state survey inspectors claim to have seen and usually defers to their judgments whether or not patients are receiving safe and effective nursing care. The Court of Appeals generally will not second-guess survey inspectors' expertise in applying Medicare standards.

**Patient Restraints – Supervision**

Federal regulations found at 42 CFR § 483.25 (h)(2)* require nursing facilities to provide adequate supervision and assistance devices to prevent accidents.

According to the court record, restraints were found attached to immovable objects in a manner warned against by the restraint manufacturer and residents thus restrained were not supervised by facility staff, creating immediate jeopardy to the health and safety of six residents.

One resident had impaired cognitive status and a history of falling out of bed. Survey inspectors five times saw her trying to get out of a bed with lowered side rails while restrained but unsupervised. While doing so she was at risk for suffocation.

*42 CFR § 483.25 refers to Title 42 of the US Code of Federal Regulations, Section 483, Sub-section .25, one of the principal regulations setting Federal standards for long-term care facilities.

Sub-section .25 is on our Internet website at http://www.nursinglaw.com/qualityofcare.pdf.

***State health agencies, acting under agreements with the US Department of Health and Human Services, conduct surveys of nursing facilities participating in Medicare to monitor the facilities' compliance with provider requirements set out in Federal regulations (42 CFR § 488.305).***

***Deficiencies in compliance with Federal standards can result in civil monetary penalties ranging from $50 to $10,000 per day, depending on the seriousness of the offense.***

***A deficiency constituting immediate jeopardy to a patient's health or safety is eligible for a penalty of 3,050 to $10,000 per day.***

***A deficiency which does not constitute immediate jeopardy, but either caused actual harm, or caused no actual harm but had the potential for more than minimal harm, qualifies for a penalty in the $50 to $3,000 per day range.***

***Penalties run from the day the violation is found until the day substantial compliance is achieved.***

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
November 3, 2006

Another resident was seen trying to remove her restraint while not supervised, placing herself at risk of suffocation.

Yet another resident was placed in an improperly-sized vest restraint and repeatedly became suspended in his restraint while unsupervised.

The court agreed with the survey inspectors decision to discount the facility's explanation. The necessity of restraints for these patients' safety did not justify improperly-sized restraints or inadequate supervision.

Likewise, the fact no actual harm occurred was irrelevant. The residents were in immediate jeopardy of serious harm. Immediate jeopardy is the only legal issue.

**Patient Restraints**
**Ongoing Assessment**

Federal regulations at 42 CFR § 483.13 say that nursing-facility residents have the right to be free from physical and chemical restraints imposed for the purposes of discipline or convenience and not required to treat the resident's symptoms.

Restraints may only be used if they are used consistent with the physician's original orders. Beyond that, orders for restraints must be continually evaluated for their necessity and effectiveness, to avoid unnecessary immobilization in violation of Federal standards.

The court agreed with the inspectors that the facility violated Federal regulations by failing to provide ongoing assessment and re-assessment of the impact and appropriateness of patients' restraints.

One resident was ordered restrained in bed pending healing of a hip fracture. The fracture had fully healed three months earlier, but she was still being restrained.

Two other residents were to be released from their restraints at least every two hours, but were kept in their restraints for three and four hour intervals while the survey inspectors were on the premises.

*(Continued on next page.)*

# Skilled Nursing, Penalties Upheld (Cont.)

*(Continued from previous page.)*

**Pressure Sores**

Federal regulations found at 42 CFR § 483.25 (c) state that:

Based on the comprehensive assessment of a resident, the facility must ensure that -

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Survey inspectors observed one resident's pressure sore increase in size over a nine-day period. He was left in a chair with no pressure relief for two and three hours on two separate occasions.

The court endorsed the surveyors' judgment that this resident's pressure sore had to have been aggravated by these long periods without movement. Furthermore, the pressure sore was not dressed, in contravention of the physician's orders, and the patient was found wearing a urine-soaked incontinence brief, which caused additional harm.

Another resident whose pressure sore also increased in size had feces come in contact with his wound.

Another resident with a growing lesion was restrained in a wheelchair without pressure relief, and yet another resident, similarly restrained in a wheelchair without pressure relief, was not toileted in time and was left sitting in his own urine.

**Incontinence Care**

Federal regulations found at 42 CFR § 483.25 (d)(2) require nursing facilities to ensure that a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

The court found one resident's care substandard in two respects: her care plan only provided for toileting in advance of need three to five times per week, and even still she was not offered toileting in advance of need as per her care plan.

That is, she spent two hours in her chair after dinner, then was put directly to bed. She soiled herself in bed about forty-five minutes later, and was not changed for forty-five more minutes.

Two other residents were not offered help to the restroom after meals and before bed as they should have been. Other residents were only cleaned and had their soiled briefs changed after they had asked to be taken to the restroom or commode and had successfully voided. **Lakeridge Villa Health Care Center v. Leavitt, 2006 WL 3147250 (6th Cir., November 3, 2006).**

# Scalding Hot Tea Spilled On Patient: Nurse Found Negligent.

The patient had been admitted to the hospital with a cough, shortness of breath, bronchitis and nasal congestion.

He asked for a cup of hot tea. His nurse got him a cup of tea but spilled the tea on him. The tea was scalding hot and burned his skin.

The legal issue for the District Court of Appeal of Florida was whether this is a case of professional malpractice.

The court found the nurse guilty of ordinary negligence but not guilty of professional malpractice.

That meant the hospital could not defend the patient's civil lawsuit on the basis that the patient's lawyer did not provide an expert witness's report as is normally expected in malpractice cases. **Quintanilla v. Coral Gables Hosp., Inc., __ So. 2d __, 2006 WL 3078909 (Fla. App., November 1, 2006).**

# Lap Sponge Left Inside: Court Splits Fault Between Nurses And Physician.

The patient's surgery to remove an ovarian cyst had apparently gone well with no complications, so she was discharged from the hospital.

Days later she began to have abdominal pain with nausea and vomiting. Her physician got an x-ray which revealed that a laparotomy pad had been left inside her abdomen. Emergency surgery was done that same day to remove the lap pad.

***The surgeon has a non-delegable legal responsibility to remove all sponges and other surgical items from the patient's body before closing the incision.***

***The surgeon, therefore, is ruled 50% responsible.***

COURT OF APPEAL OF LOUISIANA
November 3, 2006

A jury heard the patient's lawsuit. The jury's verdict held the perioperative nurses 100% at fault and ruled the surgeon was not at fault. The judge, however, overruled the jury and imposed 50% of the blame on the surgeon.

The Court of Appeal of Louisiana agreed in general terms that it is squarely a nursing responsibility to count and to account for all of the pads, sponges and other items brought onto the surgical field. The surgeon is not expected to do more than conduct a quick visual examination of the incision before closing.

However, as the court pointed out, most US jurisdictions hold the physician answerable to the patient for mix-ups in the count even when it was the nurses and not the physician who committed the actual error. **McLin v. Breaux, __ So. 2d __, 2006 WL 3103366 (La. App., November 3, 2006).**

# Endotracheal Tube Dislodged: Court Faults Nursing Care.

After coronary artery bypass surgery the patient was kept on the ventilator to assist his breathing mechanically through an endotracheal tube.

All was well the day of surgery and the next day. He was neurologically intact and able to respond to verbal commands.

The US District Court for the Eastern District of Louisiana ruled there was no negligence by the US VA Hospital's medical staff who put in his endotracheal tube the first time, did his surgery and then put him on the ventilator post-operatively.

Nor could the court find negligence in the way the medical staff responded when the nurses alerted them his trache tube had become dislodged and he was in profound cardiorespiratory distress, given the difficulty the doctors had to face re-intubating a highly agitated patient.

Fault for the patient's catastrophic hypoxic brain injury, the court ruled, lay with the hospital's nursing staff.

**Nursing Care of Trache Patient**

Weaning the patient off the ventilator began in the early morning hours. His Versed was decreased, but he became agitated and the night nurse got orders to dose his Versed back up and give him morphine. Even with more medication he was still highly agitated and was trying to pull at things with the splits on his wrists.

At the 7:00 a.m. shift change the night nurse reported everything to the day nurse coming on duty.

Then there were no nursing progress notes until 9:15 a.m., after he had already coded and been re-intubated. The court saw an inexcusable lack of attention to this patient. He should have been assessed, evaluated and closely monitored. The court believed the day nurses should have obtained orders for a tighter level of physical restraint and a higher level of sedative medication and should have kept watching him very closely.

Extrapolating backward from his blood gas readings, he was basically without oxygen from 8:14 a.m. to 8:26 a.m., the court said. **Vanhoy v. US, 2006 WL 3093646 (E.D. La., October 30, 2006).**

***Fault lies with the patient's nurses. They were responsible for the tube becoming dislodged, then for not discovering it before the patient had sustained a profound brain injury from lack of oxygen.***

***There was no breach of the standard of care by the patient's physician and the staff physicians in their efforts to re-intubate the patient once they were informed his breathing tube had become dislodged.***

***The physicians' actions cannot be seen as negligent under the circumstances because they had to deal with a highly agitated patient who was thrashing about and clenching his jaw.***

***The patient's nurses were well aware of his agitated state and his attempts to pull at anything in reach.***

***The nurses could have obtained orders to restrain him or sedate him further and should have monitored him very closely.***

***If the tube came out or was pulled out he would go into arrest and obviously would need immediate attention, but the nurses apparently were not watching closely enough to notice.***

UNITED STATES DISTRICT COURT
LOUISIANA
October 30, 2006

# Hypoglycemic Episode: School Nurse Ruled Not Guilty Of Negligence.

The young diabetic student had an individual health plan. His daily blood sugar testing was to start at 10:00 a.m.

On the day in question his 10:00 a.m. blood sugar level was 40 mg/dl, outside the 80-100 mg/dl level that was considered normal for him. The teacher notified the school nurse.

The nurse came and gave him a glucose gel tube and, as the mother had previously requested, phoned the mother about the low blood-sugar reading. The nurse also had him eat a snack of milk and crackers. By 10:30 a.m. his blood sugar was 56 mg/dl and by 10:55 it was 149 mg/dl. The rest of the day passed uneventfully.

The parents later sued the school district claiming their son had had a diabetic seizure at school that day and that the school nurse was responsible.

The Court of Appeals of Iowa approved a jury's verdict finding no liability. There was no evidence of any negligence committed by the school nurse.

Furthermore, the evidence from the parents' child psychologist was inconclusive the boy had suffered cognitive decline or psychological pathology that could be linked to a diabetic hypoglycemic episode. **Gray v. Council Bluffs Community School Dist., 2006 WL 3313947 (Iowa App., November 16, 20006).**

***There is no suspicious inference to be drawn from the records having been destroyed at the end of the school year.***

***That was standard school district practice.***

COURT OF APPEALS OF IOWA
November 16, 2006

# $O_2$ Off Briefly: Court Unable To Fault Hospital's Nurses.

The patient was taken from his home to the hospital in the throes of acute renal failure.

He was paraplegic from a gunshot wound sixteen years earlier. He suffered from congestive heart failure, diabetes and hypertension.

He had not been using his supplemental oxygen at home. When paramedics arrived they started fifteen liters of $O_2$ through a face mask and gave IV morphine, nitroglycerine and Lasix.

At the emergency room his $O_2$ was reduced to two liters per minute. After two hours of observation he was ordered admitted to a med/surg unit.

His $O_2$ was disconnected while he was being moved to the med/surg unit. He coded as they wheeled him out of the third-floor elevator. He was revived, intubated, transferred to the ICU at a nearby university hospital and discharged home one week later.

The Court of Appeals of Mississippi would not allow the patient's lawsuit to go forward.

**Failure to Follow Standard of Care Must Be Linked to Harm To Patient**

The emergency room physician and a second physician brought in by the patient's lawyer to testify as an expert witness both agreed his $O_2$ should not have been disconnected, even briefly.

The patient's nursing expert testified the patient's nurse neglected her legal duty to monitor the patient's $O_2$, that is, the nurse did not pick up on the fact that $O_2$ was not in use during the move.

However, the court sided with the hospital's physician/expert on the issue of cause-and-effect. There was no real proof that the brief interval without his $O_2$, and not the complex medical problems which brought him to the hospital, was the reason he went into respiratory arrest. **Mitchell v. University Hosp. and Clinics-Holmes County, __ So. 2d __, 2006 WL 3290844 (Miss. App., November 14, 2006).**

# Nursing Homes: Prompt Transport To Hospital Is Required.

The eighty-five year-old nursing home patient's admitting diagnoses included chest pain, new-onset diabetes mellitus, urinary tract infections, agitation, confusion, congestive heart failure, coronary artery disease, hypertension, mild hypothyroidism and a history of transient ischemic attacks.

At 7:15 a.m. he started looking pale. His $O_2$ sat was low so he was started on oxygen at 8:15 a.m. The doctor saw him at 8:30 a.m. and decided to send him to the hospital. A convalescent transport van came at 9:30 a.m. and took him to the emergency room where they admitted him.

At 7:05 p.m. he died in the hospital. The causes of death were ruled a heart attack, cardiopulmonary arrest, probable sepsis, low oxygen, low blood pressure and low heart rate.

**Nursing Home's Legal Duty To Send Resident to a Hospital**

The Court of Appeals of North Carolina agreed in general terms with the premise behind the family's lawsuit.

A nursing home's nursing staff and the resident's physician have a legal duty to see that a resident who needs to go to the hospital for care is promptly sent to the hospital.

If those responsible for a resident's care delay sending their patient to the hospital and their delay harms the resident, those responsible can be sued for damages by the resident or the resident's family.

However, according to the court, the evidence in this case was not strong enough to support a lawsuit for damages for the family against the nursing home.

It was far from clear that rushing him to the hospital early that morning would have made any real difference in his medical status or delayed his passing, the court believed. **Franklin v. Britthaven, Inc., 2006 WL 2947295 (N.C. App., October 17, 2006).**

# Nursing Documentation: Amniocentesis Did Not Cause Eye Injury.

The Supreme Court of Louisiana ruled recently that a lower court was wrong to award $500,000 in damages for a baby whose eye was allegedly punctured as a fetus by an amniocentesis needle. The Court threw out the damage award because of the thoroughness of the inpatient nursing notes generated at the hospital.

The mother had been admitted four days before her baby was born for testing to see if she was past her due date. There was no record of any eye injury until the mother brought the baby back to the hospital for a checkup five days after discharge. **Jackson v. Tulane Medical Center Hosp. and Clinic, __ So. 2d __, 2006 WL 2956134 (La., October 17, 2006).**

# MRSA: Suit Claims Nurse Should Have Seen The Signs.

A patient came to the emergency room two weeks after giving birth complaining of a two-day history of hip pain radiating down both legs.

The triage nurse reported it to the physician as a simple case of low back pain, so he gave the patient a prescription for ibuprofen and a muscle relaxant and sent her home.

She came back five days later with a methicillin-resistant Staph infection which put her in the ICU for eleven days.

The Court of Appeals of Texas refused to accept an expert witness's report laying full blame on the triage nurse for not suspecting a post-partum infection. **McKenna Memorial Hosp. v. Quinney, 2006 WL 3246524 (Tex. App., November 10, 2006).**

LEGAL EAGLE EYE NEWSLETTER
*For the Nursing Profession*

# Preemie: Multiple IV Sites, Nurses Ruled Not Negligent.

The Court of Appeals of Indiana dismissed a lawsuit filed by the parents against the hospital alleging negligence in the neonatal care of their low-birth-weight newborn.

For six days the IV sites had to be moved about on the infant's body because of problems with infusion. Some of the abandoned IV sites required repair by a plastic surgeon.

The Court of Appeals ruled the lower court erred relying on "common knowledge" as a basis for the parents' lawsuit. Instead, the competent evidence, an affidavit from a pediatric nurse, was that infusion is a common, unavoidable problem with IV therapy, particularly with premature infants. A nurse's legal duty is to monitor IV sites very closely, report to the physician, and relocate IV sites as indicated by the physician's orders if problems occur. There was no breach of the standard of care with this patient. **The Methodist Hospitals, Inc. v. Johnson, __ N.E. 2d __ 2006 WL 3278848 (Ind. App., October 2, 2006).**

# Advance Directives: Court Says When In Doubt, Resuscitate.

The Court of Appeal of Louisiana dismissed a lawsuit filed by the family of a patient who was resuscitated in a nursing home despite three advance directives in her chart, then taken to a hospital and allowed to expire based on hospital personnel's interpretation of the same advance directives. The family sought damages for the deceased's pain and suffering from the time she was resuscitated until she expired naturally in the hospital.

The court ruled the nursing home was not at fault for resuscitating the patient. One of the three advance directives, six years old, was supposed to be signed by two physicians but was only signed by one. A second advance directive said the patient should be taken to the ICU, but should not get CPR, an absurd contradiction in the court's judgment. The third was signed only by a family member, not the patient, which is not valid. **Terry v. Red River Center Corp., __ So. 2d __, 2006 WL 3307399 (La. App., November 15, 2006).**

# Nurse As Whistleblower: Disparaging Comments To Family Member Are Not Protected By Law.

Suspicions began to surface about an aide working at the nursing home. He was caught with pornographic magazines at work. Someone said he had lost his last job under clouded circumstances. One resident began clamping her legs together while being bathed, a sign she had possibly been abused by a caregiver.

The state department of health received an anonymous tip and came to the facility to investigate.

After the investigation several employees, including the night charge nurse, were issued corrective notices for failing to report signs of possible patient abuse up through the chain of command.

A few months later, having heard of the investigation, a family member of the suspected victim came in to inquire what had happened.

The night charge nurse told her flat out that policies and practices at the facility were wholly inadequate to deal with problems of patient abuse. The family member understandably became very upset and complained to management.

The night charge nurse was fired. The Court of Appeals of Ohio upheld the facility's right to fire her for disloyal conduct detrimental to her employer.

The laws which protect whistleblowers have been expressly drafted only to protect good faith reports of abuse to proper legal authorities, the court pointed out. **Thompson v. Merriman CCRC, Inc., 2006 WL 3302508 (Ohio App., November 15, 2006).**

***A healthcare employer cannot retaliate against an employee who, in good faith, makes a report of suspected abuse or neglect of a patient, or theft of a patient's property, to the state department of health or to other law-enforcement authorities.***

***Disparaging comments to others about possible abuse, however, are not protected by the whistleblower law.***

COURT OF APPEALS OF OHIO
November 15, 2006