LEGAL EAGLE EYE NEWSLETTER

December 2009 — *For the Nursing Profession* — Volume 17 Number 12

Emergency Room: Dehydrated Infant Allowed To Leave, Not Rehydrated With Oral Fluids Or IV.

The jury in the District Court, Pinellas County, Florida returned a verdict of $11,115,000.

Fault was apportioned 60% against the hospital as the employer of the emergency room nurse and 40% against the emergency room physician.

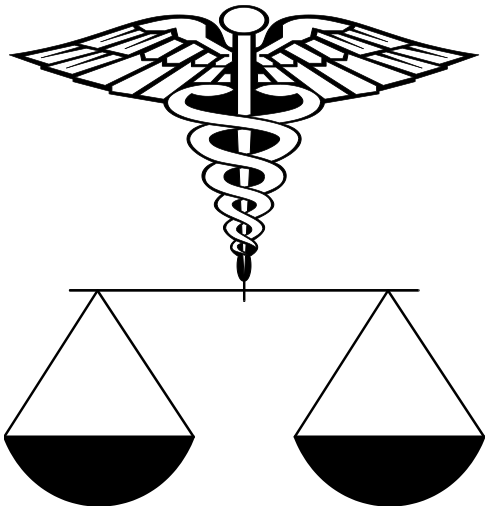
A three month-old had been vomiting and having bouts of diarrhea five times daily for three days. His seventeen year-old mother brought him to the emergency room at the insistence of her pediatrician.

He stayed in the E.R. for about four and one-half hours and then was simply released with a handwritten note from the nurse to his mother to feed him a soy beverage. The hospital's standard discharge instructions for a dehydrated infant recommend Pedialyte.

The family's lawyers pointed to significant time gaps in the E.R. flow charting when apparently nothing was being done to assess or care for him.

The boy afterward went into shock and suffered a seizure and now has significant brain damage.

Presently nine years old, he is already two years behind in school, has a low IQ and the experts say he will not be able to graduate high school or obtain gainful employment as an adult. **Smith v. All Children's Hosp., 2009 WL 3864869 (Dist. Ct. Pinellas Co., Florida, October 22, 2009).**



Based on his history, signs and symptoms, the infant should have received oral rehydration therapy under the supervision of a nurse before leaving the E.R.

If that was not successful an IV should have been started to rehydrate him.

He was discharged with a note to his mother to give him a soy beverage.

CIRCUIT COURT, PINELLAS COUNTY
FLORIDA
October 22, 2009

Fall: Nursing Home Ruled Not Liable.

The jury in the District Court, Valencia County, New Mexico ruled that the nursing home was not liable for a fall that occurred as an elderly dementia patient was arising from her wheelchair, a fall in which she sustained a brain hemorrhage from which she died.

Fall Precautions Were Appropriate Restraint Was Not Appropriate

The patient was making progress in her physical therapy. She was almost ready to start ambulating on her own.

She still had an alarm on her wheelchair to alert the nurses if she stood up. The nurses came right away when she stood up this time, but she was already lying on the floor injured.

She also had a foam lap cushion around her waist, which she was able to remove by herself and apparently did remove by herself right before she stood up and fell.

The facility's medical and nursing staff had had to make a tough judgment call. This resident was not a good candidate for a seat belt or another more restrictive restraint. While in the nursing home and the hospital before that, restraints had tended only to heighten her anxiety and her agitation and make her even more likely to try to free herself and move about on her own. **Estate of Martinez v. Laurel Healthcare, 2009 WL 3864871 (Dist. Ct. Valencia Co., New Mexico, February 20. 2009).**

www.nursinglaw.com/dec09csh8.pdf

December 2009

New Subscriptions
See Page 3

Gestational Diabetes: Large Settlement For Mismanagement Of Newborn's Hypoglycemia.

The mother developed gestational diabetes during this, her first pregnancy.

An unplanned c-section was performed after signs of fetal distress. The newborn weighed slightly more than 7 lbs. and had normal Apgar scores at birth.

The hospital's standing protocol for an infant born to a mother with gestational diabetes calls for close monitoring of the infant's blood glucose and weight gain or loss compared to birth weight.

The hospital has a schedule for starting breastfeeding and/or feeding the infant with formula or expressed breast milk based on changes in weight and the blood glucose readings.

During the night, about 53 hours after birth, the infant, whose weight had dropped 10.4% since birth, got only 15 ml of formula and the mother was not able to get him to breastfeed.

At 7:00 a.m. his blood glucose was only 15.

MEDICAL MALPRACTICE ARBITRATION
LOS ANGELES, CALIFORNIA
September, 2009

The arbitrator awarded over $9,000,000 for the infant's hypoglycemic brain damage. The arbitration hearing was convened in Los Angeles, California.

The family's attorneys convinced the arbitrator the neonatal nursing staff did not follow the hospital's complicated but basically sound protocols for staving off hypoglycemia by watching the blood glucoses and seeing that the infant is fed formula or breast milk. **Confidential v. Kaiser Foundation, 2009 WL 3862916 (Med. Mal. Arbitration, Los Angeles, California, September, 2009).**

Suicide: Hospital Ruled Not Liable.

The day before the thirty-nine year-old police officer hanged himself at home his wife and father brought him to the hospital's emergency room, concerned about his mental health.

The patient reportedly told the emergency room nurse he had given all his firearms to his father the day before.

The emergency room nurse relayed the patient's statement to the mental health professional on duty in the E.R. The mental health professional thought the patient was having an anxiety attack and recommended a full work-up. The E.R. nurse had the patient seen by the E.R. physician, then by a hospital social worker.

The consensus of all the professional staff who saw the patient was that he was suffering from anxiety, for which a Xanax prescription was written, but was not displaying grounds for admission to the hospital as a suicide risk.

The argument to the jury by the family's lawyer was that the patient's statement to the E.R. nurse about getting rid of his guns, in and of itself, obligated the hospital to offer the patient voluntary admission for mental health treatment.

The jury in the Superior Court, Morris County, New Jersey, ruled in favor of all the defendants, the nurse, the hospital, the physician and the social worker. **Estate of Cillo v. Morristown Mem. Hosp., 2009 WL 3863106 (Sup. Ct. Morris Co., New Jersey, September 23, 2009).**

E.R.: Contraband Given To Police.

The suspect defecated in his pants when he was "Tased" by the police trying to arrest him. When they brought him to the E.R. the nurse found a baggie of crack cocaine in his feces, which she turned over to one of the officers who brought him in.

The Supreme Court of Colorado did not question the nurse's conduct. The Court ruled the police had probable cause to arrest the suspect and the contraband was properly discovered incident to a lawful arrest. **People v. Brown, 217 P. 3d 1252 (Colo., October 13, 2009).**

Civil Rights: Suspect's Body Searched In E.R., Hospital Settles.

The police stopped an individual on the street, patted him down, looked in his mouth and searched his backpack. Finding nothing, they took him to the station for a strip-search, then to a local hospital E.R.

At the hospital he expressly refused to consent to treatment. Nevertheless he was placed under sedation and his rectum was examined manually and with a camera scope. Then he was forced to vomit up the contents of his stomach. His blood and urine were taken for tox screens and x-rays and CT scans were obtained. No drugs or evidence that he was under the influence of drugs or alcohol was found.

Charges of resisting arrest were later dismissed by a local magistrate.

The police who brought the suspect to the E.R. encouraged the E.R. medical and nursing staff to perform invasive procedures, under the guise of medical treatment, effectively deputizing them as law enforcement officers searching for evidence of drugs and alcohol.

UNITED STATES DISTRICT COURT
NEW YORK
July 17, 2009

The hospital paid $60,000 and the police department paid another $65,000 to settle the individual's civil rights lawsuit filed in the US District Court for the Northern District of New York.

The individual reportedly showed no signs of a medical emergency which would have justified the E.R. staff going ahead against his expressed refusal of consent. The medical staff were basically using a non-existent medical rationale to conduct an illegal search to try to turn up evidence of drug possession or intoxication for the benefit of the police officers who wanted to arrest him. **Clement v. County of Albany, 2009 WL 3863119 (N.D.N.Y., July 17, 2009).**

Civil Rights: E.R. Nurse Withheld Pain Medication From Suspect Pending Police Interrogation.

The criminal suspect's civil rights lawsuit against the hospital was based upon a note penned on the suspect's emergency department trauma flow sheet by an emergency department nurse:

MD aware of pt. c o pain. Informed by MD to wait until police are done speaking to pt. Det. Fry & Det. Anderson @ BS.

For the record, the US District Court for the Southern District of Texas pointed to the nurse's sworn testimony that explained what her note meant:

Medical doctor aware of patient complaint of pain. Informed by medical doctor to wait until police are done speaking to patient. Detective Fry and Detective Anderson at bedside.

The patient had been rushed to the hospital after being shot by police storming into a local business establishment to interdict a hostage situation that developed after a botched armed robbery attempt.

When the suspect arrived at the hospital the police were still in the process of sorting out whether the suspect in custody was the only perpetrator involved, whether other perpetrators were still holed up in the crime scene or had fled, whether there were additional hostages still being held and other critical details of the situation that was still unfolding.

A suspect in police custody has an Eighth Amendment Constitutional right not to be subjected to cruel and unusual punishment.

Cruel and unusual punishment, among other things, includes deliberate indifference by medical caregivers to the suspect's serious medical needs.

Medical caregivers do not have to be jail or prison employees for the Eighth Amendment to apply to them, if they are treating a person who is in the custody of law enforcement.

Withholding or delaying necessary critical care, including pain medication for a patient in dire need, would be considered serious indifference and cruel and unusual punishment.

Orders from the police are not relevant to a nurse's legal responsibilities.

UNITED STATES DISTRICT COURT
TEXAS
October 19, 2009

Nurse Did Not Violate Patient's Rights Court Walks a Very Fine Line

The Court was careful to point out that the nurse and her employer were spared from liability for violating the patient's Constitutional rights only because it apparently was the E.R. physician, not the police officers who were standing by, who ordered the morphine withheld so that the patient would remain lucid until the police had obtained the information they wanted.

Care Cannot Be Delayed or Withheld At the Behest of Law Enforcement

It would have been wholly improper for the nurse, the Court said, if she had a physician's order for morphine for a patient who obviously needed it, to delay or withhold the morphine at the direction of law enforcement officers, whether the officers said they just wanted the patient to remain lucid to complete their questioning or were actually prolonging the patient's agony to try to coerce a confession.

Why the physician actually held up the morphine was not clear. He might have felt it necessary to evaluate his condition further, i.e., check the patient's level of consciousness, assess his respirations and/or get the CT results back first. The nurse might have been confused and misstated the rationale for holding up the morphine.

In any event, the Court ruled, despite what the nurse herself noted, the evidence was not conclusive that the nurse delayed or withheld a needed medical intervention at the direction of law enforcement. **Gilbert v. French, __ F. Supp 2d. __, 2009 WL 3378392 (S.D. Tex., October 19, 2009).**

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Perioperative Nursing: Nurse Must Check That Equipment Has Cooled After Flash Sterilization.

The patient sued the hospital and the orthopedic surgeon's practice group after she sustained third degree burns on her upper arm from a wrist traction tower that was used in her wrist surgery.

Some of the Parts Had Not Cooled Patient Was Burned

A perioperative nurse was responsible for gathering all the instruments, supplies and equipment ordered for the case, including a wrist traction tower.

The traction tower was not sterilized after being used the day before. She put all the metal component parts in a metal pan and flash sterilized them for four minutes at 270° F. Then the nurse took the pan out of the autoclave with oven mitts, put the pan on a table in the operating room and took the lid off to allow it to cool, about an hour before the case was scheduled to start.

The orthopedic surgeon and the scrub nurse, a hospital employee, assembled the wrist traction tower on the sterile surgical field after the patient was under anesthesia, put the patient's arm in it, draped the arm and wrist and went ahead with the case.

None of the parts they touched seemed too hot. However, according to the Court of Civil Appeals of Alabama, the fact that the patient sustained burn injuries was evidence that all the component parts of the entire apparatus were not given time to cool and were not checked for residual heat before being used.

The Court was quick to throw the circulating nurse who flash-sterilized the equipment one hour before the procedure into the mix to share the blame, without explaining how she could have checked the temperature of the sterile equipment, as she would not have been able to touch it after it had been sterilized.

Padding Not Documented

The surgeon's and the nurses' surgical reports included no documentation that the traction tower's manufacturer's recommendation was followed for cloth or gauze padding to be inserted between the skin and all metal parts that might contain residual heat from recent sterilization. **Ford v. Stringfellow Mem. Hosp., __ So. 3d __, 2009 WL 3415304 (Ala. App., October 23, 2009).**

The hospital's RN director of surgical services testified that it is important for patient safety that surgical devices such as the wrist traction tower be properly cooled before being used in surgery.

The standard of care in the national medical community is that the individual person who flash sterilizes equipment to be used with a patient in surgery after flash sterilization is responsible for allowing enough time for it to cool it before it is used.

It is necessary that all component parts of the equipment be allowed to cool and be checked to make sure they are cool enough that the patient will not be injured.

The scrub nurse who helped the surgeon assemble the device on the sterile field testified that none of the parts she actually touched seemed to be too hot.

However, the fact the patient was burned is evidence that some of the parts were too hot and that the nurse's and the surgeon's actions were not up to the standard of care.

COURT OF CIVIL APPEALS OF ALABAMA
October 23, 2009

Gangrenous Appendix: Nurse's Phone Advice Implicated In Child's Death.

The parents phoned and spoke with the nurse in their pediatrician's office because their twenty-one month-old had a low grade fever, was vomiting and was showing an unwillingness to stand or walk.

The nurse told them it was influenza and that they did not need an appointment to come into the office.

The child did come in three days later. The doctor was running behind and apparently was in a hurry. He did only a very cursory exam, even though the child cried louder than the parents had ever heard before when his abdomen was poked.

The child died the next day. The coroner's report pointed to an acute appendix that had been gangrenous for two to six days. The jury in the District Court, St. Louis County, Minnesota returned a verdict of $1,250,000 against the physician, for his own negligence and as the nurse's employer. **Morrow v. Krause, 2009 WL 3802360 (Dist. Ct. St. Louis Co., Minnesota, October 26, 2009).**

Fall: One Nurse Made Bed After Back Surgery.

A $600,000 settlement awarded to a patient in Massachusetts was reported on condition that the identities of the parties and even the city where the lawsuit was filed remain confidential.

The patient had anterior spinal release surgery from T10 through L1, posterior osteotomies from T9 to L1 and a posterior fusion from T4 through L3.

Five days after surgery he fell out the other side of the bed while a hospital nurse was changing the bed linens. He sustained a new fracture of the L3 vertebra.

The patient claimed his condition mandated at least one other nurse or other caregiver should have been involved. **Confidential v. Confidential, 2009 WL 3748654 (Massachusetts, April 7, 2009).**

Lymphoma: Nurse Practitioner Settles With Patient Over Delay In Diagnosis.

The thirty year-old patient saw a nurse practitioner in her neighborhood health clinic for symptoms of heaviness in her chest and "pins and needles" in her arms, especially when lying in bed.

The nurse practitioner noted that one of the patient's tonsils was enlarged, but the physical exam was otherwise unremarkable. She obtained an EKG and sent the patient for a chest x-ray, basically to calm her fears. The chest x-ray was read by a radiologist as normal.

The nurse practitioner's diagnosis was an allergy brought on by a high seasonal pollen count, for which she prescribed an allergy medication.

The patient returned several times over the next few months with the same symptoms. A new chest x-ray revealed the left lung was compressed and a CT showed a large mediastinal mass, which was promptly removed surgically.

The surgery was successful, but the patient still received a $1,200,000 settlement of her case filed in the Superior Court, Suffolk County, Massachusetts for shortened life expectancy. **Confidential v. Confidential, 2009 WL 3748653 (Sup. Ct. Suffolk Co., Massachusetts, June 1, 2009).**

Hoyer Lift: Two Persons Required.

The estate of a deceased dementia patient obtained a $600,000 settlement from the nursing home because the patient's head struck the side rails of the bed on more than one occasion while she was being moved with Hoyer lift.

The family's lawyers were prepared to argue in the Superior Court, Bergen County, New Jersey, that two persons are always necessary for safe operation of a Hoyer lift. **Estate of James v. Bergen Reg. Med. Ctr., 2009 WL 3863236 (Sup. Ct. Bergen Co., New Jersey, September 11, 2009).**

Arbitration: Spouse Had No Authority To Sign Arbitration Agreement.

An elderly nursing home resident fell and broke her hip getting out of bed by herself while heavily medicated. She sued the nursing home for negligence.

At this point in the litigation the issue is whether the case belongs before a jury in civil court, as the patient claims, or before an arbitration panel in alternative dispute resolution, as the nursing home insists.

The law favors alternative dispute resolution through arbitration.

However, neither side is bound to arbitrate unless there is a valid arbitration agreement.

UNITED STATES DISTRICT COURT
ARIZONA
November 12, 2009

The US District Court for the District of Arizona, without passing judgment on the allegations of negligence, has ruled against the nursing home on the issue that the case does not belong in arbitration.

Power of Attorney

The patient herself never signed the arbitration agreement. Her power of attorney named her son as her primary attorney-in-fact and her husband as secondary, with authority to sign contracts only in the event the primary was unavailable or incapacitated. Her husband signed the arbitration agreement at the time of admission. However, there was no evidence the son, the proper party, was unable to sign for her.

Husband Was Told He Had to Sign

The husband was told he had to sign all the papers, including the arbitration agreement, before his wife could be admitted. A nursing-home arbitration agreement must be voluntary; it is void if held out as a condition of admission. **Bossort v. Kindred Nursing, 2009 WL 3818858 (D. Ariz., November 12, 2009).**

H1N1Blood Donor Screening: New Recommendations From CDC.

On November 19, 2009 the US Centers for Disease Control and Prevention announced the availability of *Recommendations for the Assessment of Blood Donor Suitability, Blood Product Safety and Preservation of the Blood Supply in Response to Pandemic (H1N1) 2009 Virus*.

The CDC emphasizes that the document is being distributed only for the purpose of soliciting comments and it is not mandatory at this time.

The 10-page, non-copyrighted document is available from our website at www.nursinglaw.com/H1N1.pdf.

FEDERAL REGISTER November 19, 2009
Pages 59982-59983

Invasion Of Privacy: Plastic Surgery Patient's Photos Published.

Before having surgery to remove excess skin remaining after major weight loss the patient signed a consent form allowing the plastic surgery clinic to take "before and after" photos of her.

When signing the consent form she expressly declined to initial check-boxes that would have allowed uses of the photos above and beyond documenting her case in her own medical chart.

The clinic's office nurse gave a local newspaper reporter a computer disc containing the photos. Two of the patient's photos, without her face showing or her name being revealed, appeared in the print and online versions of the reporter's story.

The US District Court for the Eastern District of Missouri ruled the patient could sue the clinic for negligence, invasion of privacy and wrongful commercial appropriation. **"Jane Doe" v. Young, 2009 WL 3680988 (E.D. Mo., October 30, 2009).**

G-Tube Reinsertion, Death: Staff Nurse, DON Charged With Felony Dependent Adult Abuse.

The patient was a young man who had nearly drowned in a surfing accident which rendered him semi-comatose and paraplegic. Three months after his accident he was admitted to a twelve-bed long-term care facility specializing in the care of accident victims.

For six months he was one of only six patients at the facility until he died from peritonitis from nutrition introduced into his abdominal cavity instead of his stomach because his gastrostomy tube was incorrectly replaced by a staff nurse.

Staff Nurse, DON Charged With Felony Dependent Adult Abuse

The California Court of Appeal agreed with the prosecuting attorney that there were grounds to prosecute the nurses involved in the patient's care. The Court of Appeal reversed the county Superior Court judge's decision to dismiss the charges.

Staff Nurse

The patient's licensed vocational nurse found the patient's g-tube lying beside him in bed at 3:00 a.m. She did not know how long it had been out. She wrote a progress note that the patient had pulled it out, but the nurse did not actually see that happen.

The LVN decided to go ahead without calling the physician, without contacting the director of nursing and without checking the physician's standing orders.

The physician's orders were for a 14 French and the LVN went ahead with a 20 French, but the Court did not see that mistake in and of itself as a criminal act.

The LVN's competency in g-tube replacement had been checked out six years earlier at the facility but she had had no in-service refresher training since then. The Court stated for the record she should have known she was not qualified at this point in time to replace a g-tube.

After she pushed in the new tube she used a stethoscope to listen for air entering the stomach from a syringe, and heard a "whooshing" sound.

Then she tried to aspirate gastric fluid from the stomach. When nothing came back she concluded that meant the stomach was empty and it was necessary to feed the patient. She decided to give his scheduled feedings at 3:00 a.m. and 6:00 a.m.

The dependent adult abuse statute is usually used to prosecute relatives or other lay caregivers who seriously neglect a family member's needs, but there is no reason for the statute not to apply to a professional caregiver.

Dependent adult abuse is willful conduct that causes a dependent adult to suffer under circumstances likely to produce great bodily harm or death.

Intent to injure the victim is not required; criminal negligence is sufficient.

Criminal negligence is aggravated, culpable, gross or reckless conduct which is a departure from the conduct of an ordinarily prudent person which a reasonable person would appreciate poses a risk to human life.

CALIFORNIA COURT OF APPEAL
October 29, 2009

It seemed to the LVN that the patient tolerated the 3:00 a.m. feeding well. That is, after the 3:00 a.m. feeding the patient was sweating, grimacing and groaning, but the LVN did not think the patient was not tolerating his feeding because she had seen him sweat, grimace and moan before.

Nevertheless, at 4:00 a.m. she gave ibuprofen for "discomfort with g-tube removal" and Ativan for "g-tube reinserted, increased anxiety."

The LVN ended her night shift at 7:00 a.m. She reported to the day nurse she had changed the g-tube during the night. The patient was still sweating and grimacing, but the day nurse believed the patient was about to have a bowel movement.

The day nurse, who had been on the job only two weeks, tried to aspirate the stomach before giving the morning meds and nutrition. She got little or nothing back because, she believed, he had not had a bowel movement. His feeding started going down slowly but she was able to complete it with him upright on a tilt table.

The day CNA, who had worked with the patient the whole six months he had been there, became very concerned when she took his a.m. vitals. When the director of nursing, an RN, came in at 9:00 a.m. the CNA relayed her concerns to him.

Director of Nursing

The DON helped the physical therapist with the morning therapy session in which the patient was stood upright in a standing frame. The patient was breathing rapidly and sweating profusely and his eyes were wide open, whereas he usually closed his eyes during therapy.

The CNA kept watching the patient and taking vitals. By 11:00 a.m. he was running a 101° fever. She insisted several times the DON come and check on him.

The DON finally took vitals and got an O_2 sat at 1:15 p.m. He phoned and left a message for the physician that something was seriously wrong.

A 911 call was placed at 3:21 p.m. The dispatch records indicated the caller did not report it as an emergency. Paramedics arrived seven minutes later and found the patient dead.

The Court faulted the director of nursing not only for his substandard conduct as a hands-on caregiver on the patient's last day, but also for substandard performance as the supervisor of nursing competency and practices at the facility.

The Court accepted expert medical testimony for the prosecution that the DON should not have allowed a nurse to reinsert a g-tube who was not competent to do so. She should have known she was to send the patient to the hospital for it to be done by a gastroenterologist who could follow up with an endoscopic procedure to verify correct placement. A nurse not familiar with g-tube feeding should not be allowed to do it until properly trained. **People v. Medlin, 100 Cal. Rptr. 3d 810 (Cal. App., October 29, 2009).**

Service Animal: Nursing Home Did Not Discriminate.

A hospital social worker was trying to discharge a forty-five year-old disabled individual from the hospital's emergency department to a nursing facility.

The man's medical problems included frontal lobe damage, severe depression, anxiety attacks, grandiose delusions, obesity, high blood pressure, hypertension, lung disease, sleep apnea, coronary artery disease and difficulty walking for which he normally used a wheelchair.

The social worker believed it was better to send him to a supportive care-giving milieu rather than back to his home environment which he said had been stressing him out.

A few years earlier a mental health therapist had got him a dog from an agency which raises and trains service animals for the disabled. This particular animal had been rejected by the service-animal agency as not suited for the job of service animal, was not helping him as a service animal would and was basically just a pet he was keeping for emotional comfort.

Admission to Nursing Facility Denied Pending Dog's Clean Bill of Health

When the individual arrived to check in at the nursing facility he was told he could not check in with his dog until the dog's vaccination records were supplied by the veterinarian. He went home.

Later he filed a civil rights complaint alleging disability discrimination.

The Court of Appeals of Ohio stated that, as a general rule, it is disability discrimination for a nursing home to deny a disabled person the right to bring in his or her service animal.

This nursing home allowed pets who were not service animals, and the facility would have committed discrimination by not following its own policy.

However, whether or not an animal actually is a service animal for the disabled, a nursing facility's responsibility for the health and safety of its residents permits the facility to insist on a clean bill of health and vaccination records from a veterinarian before allowing an animal to move in, the court ruled. **Ohio Civil Rights Commission v. Mellon Ridge, 2009 WL 3634200 (Ohio App., November 2, 2009).**

English-Only Rule: Court Upholds Hospital's Anti-Splitting Policy.

The US District Court for the Southern District of New York declined to rule that the hospital's psychiatric unit's very limited English-only rule was evidence of a climate of discrimination against Hispanic employees.

The population served by the hospital's mental health services is about 50% bilingual Spanish-English and 30% monolingual Spanish. Most staff are bilingual Hispanics and Spanish fluency is a preference factor for hiring of non-licensed patient-care personnel.

Conversations are not allowed been staff members in Spanish which can be overheard by patients.

As a general rule an English-only rule is considered discriminatory.

Nevertheless, this hospital has a legitimate reason for its anti-splitting policy on the psychiatric unit.

The medical staff have determined it is not in the patients' best interests to ignore the authority of and to refuse to cooperate with English-speaking staff after overhearing other staff conversing in Spanish.

UNITED STATES DISTRICT COURT
NEW YORK
November 3, 2009

The hospital's policy for English preference is not out of line, the Court said, even though on many occasions employees like the employee in question are expressly directed to speak Spanish with patients who do not speak English or to translate for the benefit of staff members who do not speak Spanish. **Perez v. New York and Presbyterian Hosp., 2009 WL 3634038 (S.D. N.Y., November 3, 2009).**

Limited Male Staffing: Court Sees Evidence Of Discrimination.

It came to light in a pre-trial deposition in a male nursing home employee's gender-discrimination lawsuit that the facility had a policy of minimizing male staffing on the night shift for safety reasons.

It was not clear from the court record whether that policy had any direct impact on the conditions of employment of the male employee in question.

However, the US District Court for the Western District of Oklahoma ruled such a policy, discriminatory on its face and not supported by any *bona fide* occupational qualification, was relevant on the issue of an overall climate of discrimination against male staff at the facility. **Blair v. Colonial Plaza, 2009 WL 3806778 (W.D. Okla., November 12, 2009).**

Hospital Gown Change: Patient's Rotator Cuff Reinjured After Surgery.

A judge in the District Court, Tangipahoa Parish, Louisiana awarded the patient a $49,900 judgment against the hospital.

The patient was on a med/surg floor recovering from rotator cuff surgery when a nursing assistant pulled his hospital gown forcefully upward, twisting his arm and pushing it against his chin. The patient reportedly heard a pop and felt pain immediately in the operative shoulder.

Six months later he had a second surgery to redo the rotator cuff reconstruction. A complication in the case for the patient was the fact he did yard work and exercises not recommended by his physical therapist during the time between his two surgeries. The judge reduced his damages by 25% to account for the patient's own negligence. **Hester v. Hospital Service Dist., 2009 WL 3824818 (Dist. Ct. Tangipahoa Par., Louisiana, August 6, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Patient Assaulted: Nursing Home Not Able To Explain Bruising On Body.

After the elderly Alzheimer's patient passed away her family sued the nursing facility. They claimed the noticeable bruising they had seen on her body was caused by physical and sexual assaults.

No Nursing Documentation To Account For Bruising

The physician retained as an expert by the nursing facility testified that the heparin the patient was getting made her highly susceptible to bruising. However, the physician was not able to point to any specific event that could have caused the bruising. He conceded that any unusual occurrence like a fall, if it had happened, should have and would have been documented in the nursing notes. That left open the possibility that the resident was assaulted as was claimed.

The jury in the Circuit Court, Macomb County, Michigan awarded $240,000 to the family. **Estate of Adam v. Sisters of Bon Secours, 2009 WL 3748686 (Cir. Ct. Macomb Co., Michigan, January 28, 2009).**

Fall: Jury Convinced Urine On The Floor Was The Cause.

The eighty-eight year-old patient came to the nursing facility following three days in the hospital after she fell and broke her arm at home.

During the night she fell and struck her head on the floor while getting out of bed unassisted. Nursing home staff found her right away. They checked her blood pressure, saw that her pupils were equal and reactive and put her back to bed.

At 6:15 a.m. she was found unresponsive and an ambulance was called. At 9:55 a.m. she died in the hospital from subdural hematomas.

No Nursing Documentation Details of Patient Being Found on the Floor

The family's lawyer convinced the jury she slipped and fell on urine on the floor. There was no nursing documentation of the pertinent details, so the nursing facility was left trying to defend only by saying that it had a policy to check and clean the floors on a regular basis. The jury in the Superior Court, Suffolk County, Massachusetts awarded the family $97,307. **Estate of Reilly v. Oakwood Living Ctr., 2008 WL 7070100 (Sup. Ct. Suffolk Co., Massachusetts, July 22, 2008).**

Sleeping On Suicide Watch: Court Says Hospital Has Grounds To Fire For Serious Misconduct.

A hospital employee filed for unemployment after she was terminated when a nurse caught her sleeping while she was assigned to sit with a patient on suicide watch.

The Court of Appeals of Minnesota ruled the hospital had grounds to terminate her for misconduct and she was not eligible for unemployment.

Prior Warning Had Been Given For Sleeping On The Job

Although it is not necessary to give an employee a warning before terminating the employee for serious misconduct, this employee had been caught sleeping on suicide watch approximately one year before this incident and had been warned in writing that another similar incident would result in disciplinary action up and to including her termination.

Employment misconduct is defined as intentional, negligent or indifferent conduct that clearly displays a serious violation of the standards of behavior the employer has the right to expect, or a substantial lack of concern.

The hospital fully investigate the facts before taking action. The nurse who caught her asleep and the patient himself verified what happened.

COURT OF APPEALS OF MINNESOTA
November 3, 2009

Employee Was Not Entitled To Reasonable Accommodation

The Court threw out the argument offered by the employee in her defense that her supervisors knew about her busy schedule, attending school, caring for her family and working the night shift, and therefore had an obligation to provide reasonable accommodation, that is, an assignment where falling asleep on duty would not be an issue with patient safety.

The hospital's internal investigator spoke with the staff nurse who caught her sleeping. The investigator also spoke with the patient, who said the aide was asleep that night and the night before. The patient's allegedly questionable mental state was not an issue the aide could raise, the court said. **Wuorinen v. St. Mary's, 2009 WL 3574238 (Minn. App., November 3, 2009).**