LEGAL EAGLE EYE NEWSLETTER

December 2010 *For the Nursing Profession* Volume 18 Number 12

PEG Feeding, Aspiration: Nurse's Late-Entry Progress Note Fails To Persuade The Jury.

The post-operative patient died in the hospital from a respiratory infection after aspirating material from a PEG tube feeding into her lungs.

The Court of Appeals of Louisiana approved the jury's award of $478,000 to the family for the nurses' negligence lying the patient flat on her back while feeding her.

The Court looked at the evidence in the case which tended to support the jury's decision.

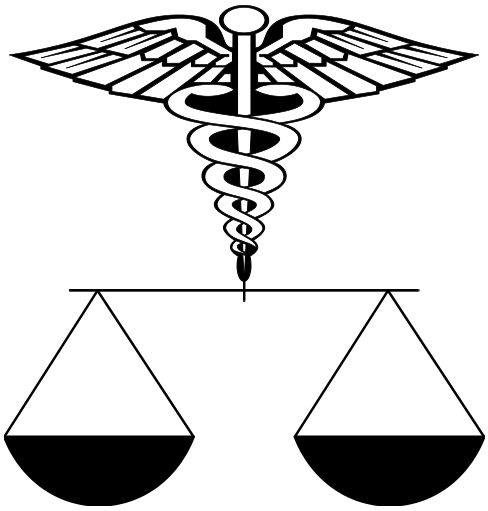
The last nursing progress note before the patient was fed at 6:00 p.m. was written at 7:15 a.m. and had the head of the bed elevated 20°.

The next nursing progress note was at 7:00 p.m. when surgical drains were removed and the dressings changed. It mentioned nothing about the elevation of the head of the bed.

The next progress note after that was at 7:15 p.m. when the patient began to complain that she could not breathe, and it also said nothing about the elevation of the head of the bed.

A family member was allowed to testify the patient told her right before she expired that they had laid her flat on her back during her last feeding.

The Court ruled the patient's statement qualified as a "dying declaration" which is exempt from the rule against hearsay.



The last nursing progress note, almost eleven hours before the tube feeding in question, had the head of the bed elevated only 20°.

There is no objective basis in the record for the hospital to claim the head of the bed was elevated to 30° as it should have been to prevent aspiration of nutrition into the patient's lungs.

COURT OF APPEAL OF LOUISIANA
November 17, 2010

Nurse Charted Defensively

The next evening the nurse who had fed the patient the evening before wrote a progress note, *"It was brought to my attention that spouse c/o pt being laid flat during feeding or during removal of drains ... Pt was fed c HOB 40° . There were 3 nurses in the room when drains were pulled.* [names of three nurses] *all witnessed that pt's HOB was elevated 30°... I do not know of any other nurses entering the room & laying pt. flat."*

At trial, however, the nurse's late progress only served to provide the family's lawyers an avenue to attack her competence as a nurse and her credibility as a witness.

Two of the nurses expressly named in the note testified they were in the room when the drains were removed, but not when the patient was fed, and the third testified he was never in the room at all. The references to 40° when she was fed and 30° when the other nurses were in the room was a fatal inconsistency, in the Court's view.

The family's nursing expert testified it was below the standard of care to lay the patient flat during her feeding without the head elevated at least 30°. **Welch v. Willis-Knighton, __ So. 3d __, 2010 WL 4629930 (La. App., November 17, 2010).**

Medicare/Medicaid: New CMS Regulations Define A Same-Sex Domestic Partner As A Family Member For Hospital Visitation Rights.

On November 19, 2010 the US Centers for Medicare and Medicaid Services (CMS) announced new regulations for hospitals that expressly include same-sex domestic partners in the definition of "family" for purposes of patients' visitation rights.

The new regulations take effect on January 18, 2011.

The new regulations were prompted by an April 15, 2010 memorandum from the President to the US Secretary of Health and Human Services addressing the plight of individuals who are denied the comfort of a loved one, whether a family member or a close friend, at their side during a time of pain or anxiety after they are admitted to a hospital.

The President's memorandum indicated that these individuals are often denied this most basic of human needs simply because the loved ones who provide them comfort and support do not fit into a traditional concept of "family."

The fundamental rationale for the new regulations is to protect each patient's basic right to participate in decisions affecting the patient's own health care.

However, CMS points out that excluding visitors on the basis of no legal relationship with the patient can lead to missed opportunities for physicians and nurses caring for the patient to gain valuable patient information with respect to the patient's medical history, conditions, medications and allergies from those who know the patient best, particularly if the patient has difficulty recalling or articulating or is totally unable to recall or articulate vital personal information.

According to CMS, many times these individuals who may know the patient best act as intermediaries for patients, helping to communicate patients' needs to hospital personnel.

Restricted or limited hospital visitation can effectively eliminate these advocates for many patients, potentially to the detriment of the patient's health and safety.

FEDERAL REGISTER November 19, 2010
Pages 70831-70844

PART 482
CONDITIONS OF PARTICIPATION FOR HOSPITALS

Sec. 482.13 Condition of participation: Patient's rights.

* * * * *

(h) Standard: Patient visitation rights.

A hospital must have written policies and procedures regarding the visitation rights of patients, including those setting forth any clinically necessary or reasonable restriction or limitation that the hospital may need to place on such rights and the reasons for the clinical restriction or limitation.

A hospital must meet the following requirements:

(1) Inform each patient (or support person, where appropriate) of his or her visitation rights, including any clinical restriction or limitation on such rights, when he or she is informed of his or her other rights under this section.

(2) Inform each patient (or support person, where appropriate) of the right, subject to his or her consent, to receive the visitors whom he or she designates, including, but not limited to, a spouse, a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(3) Not restrict, limit, or otherwise deny visitation privileges on the basis of race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(4) Ensure that all visitors enjoy full and equal visitation privileges consistent with patient preferences.

CMS's announcement dated November 12, 2010 is available on our website at http://www.nursinglaw.com/CMS111910.pdf.

FEDERAL REGISTER November 19, 2010
Pages 70831-70844

Editor's Note: The new regulations appear to be an official response from the Centers for Medicare and Medicaid Services to two recent groundbreaking court cases

A case from Washington State faulted an ICU nurse who excluded the patient's domestic partner from her bedside. *Definition Of Family Member: Court Allows Suit Against Critical-Care Nurse Who Excluded Life-Partner From The Room.* Legal Eagle Eye Newsletter for the Nursing Profession (16)1, Jan. '09 p. 8.

A case from Florida upheld the caregivers' decision to exclude the life partner, although not for the sole reason she was a same-sex life partner. *Definition Of Family Member: Court Sets Limits On Patients' Life-Partners' Rights.* Legal Eagle Eye Newsletter for the Nursing Profession (16)11, Nov. '09 p. 1.

When Can Visitors Be Excluded For Medical Reasons?

In the Florida case the court validated the hospital's decision to exclude the life-partner as well as other visitors who might have got in the way while critical-care interventions were underway.

In the Washington case the court faulted the nurse because other visitors were being allowed in, but not the patient's life-partner, apparently only because of prejudice against the sexual orientation of the patient who had a female life-partner rather than a male husband.

The opening paragraph of the new regulations requires hospitals to define in advance the criteria for caregivers' decisions when visitors can and cannot visit.

Same-Sex Domestic Partner Is A Family Member

In the Florida case the patient's life partner also happened to be the person named in her durable power of attorney as her surrogate healthcare decision-maker.

She was finally allowed to participate in the patient's care, albeit from the waiting room, only after she had a copy of the power of attorney faxed to the hospital.

Sections (2) through (4) of the new regulations would have made that unnecessary as a same-sex domestic partner is expressly defined as a family member.

Psych Nursing: Nurse Assumed Patient Was Acting Out, Not Guilty Of Abuse Or Neglect Of Her Patient.

An RN had been working at the state psychiatric hospital for more than fifteen years without ever being accused of patient abuse or neglect.

The ward where she worked housed patients known at times to act out aggressively toward staff members. The RN had been assaulted on numerous occasions and was physically smaller than most of the patients, including the females.

She heard a commotion and left the nurses station to investigate. She found an adult female patient lying face down on the floor with her eyes closed. The patient's clothing was soaked with urine. The patient did not respond to the nurse when she shouted at her. The nurse checked and found that the patient was breathing.

The RN was familiar with this particular patient. Based on her familiarity with the patient the nurse assumed the patient's behavior was a display of mental-health issues rather than a physiologic medical emergency.

She decided the next indicated action was to get the patient up, get her bathed and change her clothing, something which the RN was not physically capable of doing by herself. The unit was short-staffed that day and she had to leave the patient alone on the floor to go and look for at least one other staff person to assist her.

Many of these psychiatric patients are unpredictable.

It is not uncommon for them to lie on the floor and urinate and defecate on themselves.

The facility has a general policy to promote patient dignity, which means that patients are not supposed to be allowed to lie on the floor.

Nurses have no specific written guidance from the facility to be followed when a patient is found on the floor, but general nursing standards would call for the patient to be encouraged to get up and sit in a chair.

If the patient does not respond to verbal encouragement, which is not uncommon with psychiatric patients, the nurse should provide further assessment, which includes checking to see that the patient is breathing.

SUPERIOR COURT
NEW CASTLE COUNTY, DELAWARE
October 29, 2010

Four minutes after she left the patient an aide came and told the RN the patient was not breathing. The RN, two other nurses and two aides rushed to the patient's side. They started CPR and successfully revived the patient.

Although the RN did not see it happen before her interaction with the patient, a surveillance video camera in the corridor caught the patient leaving her room, lying down on the floor, raising her head several times and rolling herself over on her side.

No Abuse or Neglect of Patient

The RN was reported to the state division of long term care. A hearing officer found her guilty of abuse for allegedly leaving the patient unattended during a life-threatening medical emergency.

On appeal, however, the Superior Court, New Castle County, Delaware ruled there was no abuse or neglect.

It would be abuse not to begin resuscitation immediately with a patient who is not breathing. Outside an acute care hospital, where emergency medical care is not immediately available on site, someone must also call 911 immediately.

Here, however, the nurse assessed the patient and found she was breathing before leaving her. In leaving her patient the RN was not ignoring or neglecting her patient's needs but was going for the help she needed to meet her patient's needs after making an assessment that the patient was having a psychiatric episode and not having a medical emergency, the Court pointed out. **Jain v. Del. Dept. of Health & Social Services, 2010 WL 4513438 (Sup. Ct. New Castle Co., Delaware, October 29, 2010).**

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Labor & Delivery: Patient Arrests After Epidural Injection.

The twenty-five year-old patient was admitted to the hospital's labor and delivery unit for the birth of her child.

Shortly after an epidural was started she went into cardiopulmonary arrest.

The baby was delivered by emergency cesarean and has fortunately been spared from anoxic neurological injuries.

The mother, however, has severe permanent brain damage from lack of oxygen during a fifteen minute delay by her caregivers before starting to aerate her by bagging her with an ambu bag and a further two minutes before starting CPR.

The anesthesiologist gave a test dose containing Sufenta which he injected into the subarachnoid space.

The patient's room on the labor and delivery unit did not contain necessary equipment to respond to respiratory distress or cardiac arrest, complications which are known to be possible during administration of an epidural anesthetic.

CIRCUIT COURT
CHAMPAIGN COUNTY, ILLINOIS
March 1, 2010

The judge assigned by the Circuit Court, Champaign County, Illinois acted as mediator in reaching a $12,000,000 settlement to be paid jointly by the hospital and the anesthesiologist's medical practice group.

The money will take care of the mother's considerable medical expenses to date as well as provide monthly allotments to the family who are expected to provide a lifetime of special care. The lawyers will also receive fees of over $3,000,000. **Ravanh v. Provena Hosp., 2010 WL 4633526 (Cir. Ct. Champaign Co. Illinois, March 1, 2010).**

Ectopic Pregnancy: Nurse Midwife Is Faulted.

The thirty year-old patient had a prior ectopic pregnancy which ended when her right-side fallopian tube had to be removed after it ruptured. After the patient became pregnant again four years later she came in for a clinic visit because she was spotting and having left-sided flank pain with nausea and vomiting.

She revealed to the nurse midwife her history of a prior ectopic pregnancy that had led to removal of a fallopian tube.

The nurse midwife filled out a referral form for a sonogram for her patient to go for right away, but the form never left the patient's chart, the patient never went for the sonogram and the nurse midwife did not look for the results or even follow up to see if she had had the sonogram.

Six days later the patient was diagnosed in the E.R. with an ectopic pregnancy and a ruptured fallopian tube which had to be removed at the hospital.

She now cannot conceive naturally although she can, at least in theory, still conceive by *in vitro* fertilization.

The nurse midwife did not see to it that a sonogram was done. That and other testing, if done promptly, could have determined it was another ectopic pregnancy in time to save her fallopian tube.

The patient should have been informed her symptoms were consistent with another ectopic pregnancy and sent immediately to the emergency room.

CIRCUIT COURT
BALTIMORE, MARYLAND
March 23, 2010

The jury in the Circuit Court, Baltimore, Maryland returned a verdict of $2,500,000 for the patient. **Williams v. Hemphill, 2010 WL 4633368 (Cir. Ct. Baltimore, Maryland, March 23, 2010).**

Gastrostomy: Nurses Failed To Confirm Location Before Feeding The Patient.

The patient was only eighteen years of age when he sustained a major head injury in a motor vehicle accident which left him in a persistent vegetative state.

A gastrostomy tube was placed in his abdomen for feeding and administration of medications while he was still a patient in the university teaching hospital where he was taken after his accident.

After the tube was removed and repositioned the placement of the tube in the stomach was not confirmed by the physician who repositioned the tube or by the nurses caring for the patient before the nurses fed him nutrition through the tube.

Nutrition getting into the abdomen outside of the stomach resulted in systemic infection which required extensive abdominal surgeries and extra time in the hospital before the patient was transferred to long term care.

Verifying correct placement of a gastrostomy tube is a responsibility that falls on the physician as well as the nurses caring for the patient, according to the expert testimony in this case.

SUPERIOR COURT
SACRAMENTO COUNTY, CALIFORNIA
February 26, 2010

The jury in the Superior Court, Sacramento County, California returned a verdict of $456,745 for the patient.

The expert testimony in the trial reportedly convinced the jury that the nurses' as well as the physician's actions fell below the standard of care. The experts also convinced the jury that the patient, although unable to communicate to his caregivers, was nonetheless capable of experiencing pain in his condition due to his caregivers' negligence. **Garcia v. Univ. of California, 2010 WL 4462084 (Sup. Ct. Sacramento Co., California, February 26, 2010).**

Patient's Fall: Jury Finds No Lapse In Nursing Judgment.

The eighty-nine year-old patient was in the hospital being treated with antibiotics, supplemental oxygen and bed rest for an upper respiratory infection .

While two nurses were trying to ambulate the patient to the bathroom her legs gave out completely and it was decided to lower her to the floor because the nurses were not able to hold her up. During the process both her femurs were fractured.

The patient's doctor had said he wanted the patient to be encouraged to get out of bed. She had been able to walk at home unassisted the same distance it was to the bathroom in her room.

When a patient has not had a procedure and does not have a medical condition which prohibits ambulation, the nurses may increase the patient's activity level according to the patient's ability.

COURT OF COMMON PLEAS
ALLEGHENY COUNTY, PENNSYLVANIA
September 29, 2010

The jury in the Court of Common Pleas, Allegheny County, Pennsylvania ruled the nurses were not negligent.

The jury did not buy the argument that the physician's order to get the patient up out of bed only meant she was to be transferred to a bedside chair but prohibited ambulating the patient a short distance.

The jury also was not persuaded that a patient's ability to ambulate with assistance may only be determined by a physician or a physical therapist and not by a nurse. Nor was the argument given credence that the patient should have been on portable oxygen while being ambulated. **Czekalski v. Alle-Kiski Med. Ctr., 2010 WL 4633518 (Ct. Comm. Pl. Allegheny Co, Pennsylvania, September 29, 2010).**

Psychotropic Meds: Patient Gets Settlement For Lack Of Informed Consent.

The settlement in the patient's favor was reported on condition that the identities of the patient and the nursing home be kept confidential.

The eighty-seven year-old nursing home patient was given multiple doses of psychotropic medications without his consent, that is, four doses of Risperdal, three oral and one IM, eight oral doses of Xanax, seven oral doses of Ambien and an IM injection of Haldol.

After receiving the medications the patient had to be hospitalized for over a month for treatment of delirium and partial paralysis, but he has now recovered and has been restored to his previous state of health.

The nursing home was cited for violation of the state's nursing home residents' bill of rights.

Before administration of any psychotropic medication state law requires a nursing home to verify that documentation is present in the patient's chart that the patient's physician has obtained informed consent from the patient.

This is not the case when there is documentation that an emergency exists in which immediate action must be taken.

SUPERIOR COURT
SANTA CRUZ COUNTY, CALIFORNIA
April 20, 2010

The patient received a settlement of $375,000 as the case filed in the Superior Court, Santa Cruz, California was about to be assigned to a judge for jury trial. **Confidential v. Confidential, 2010 WL 4633544 (Sup. Ct. Santa Cruz Co., California, April 20, 2010).**

Overdose: Widow Of Patient Obtains Jury Verdict.

The seventy-six year-old patient was admitted to a skilled nursing facility for rehab following hospitalization for a non-displaced hip fracture.

His admitting diagnoses included diabetes, coronary artery disease, Parkinson's disease and orthostatic hypotension.

He died in the nursing facility one week after admission.

The facility's medication administration records were incomplete to the point it could not be determined how much morphine he had or had not received. Nor were nursing progress notes available from which it could be determined whether or not he was showing signs of toxicity.

However, the toxicology report from the autopsy revealed a morphine level well beyond the therapeutic range. From that fact alone the jury in the Circuit Court, Monroe County, Michigan was able to find the patient's nurses and physician negligent and award the widow $4,850,000. **May v. Mercy Memorial Nursing Ctr., 2010 WL 4633418 (Cir. Ct. Monroe Co., Michigan, June 1, 2010).**

Medicare: New Regulations For Home Health, Hospice Care.

On November 17, 2010 the US Centers for Medicare and Medicaid Services (CMS) announced new regulations which take effect January 1, 2011 affecting Medicare reimbursement for home health and hospice services.

One of the important points is clarification of the requirement for a face-to-face encounter between the home health or hospice patient and the physician who will certify the patient's eligibility.

We have the full text of CMS's announcement on our website at http://www.nursinglaw.com/CMS111710.pdf.

FEDERAL REGISTER November 17, 2010
Pages 70372-70486

Emergency Room: Nurses Blamed For Patient's Death From MI After Discharge Home.

The patient came to the E.R. with chest pains.

She was given two EKG's, one which was normal and one which showed a septal infarct whose age could not be determined. A chest x-ray was read as normal. She was seen by the physician and discharged after receiving a dose of oral captopril and an albuterol inhalation treatment in the E.R.

Early the next morning she was taken by ambulance from her home to another hospital where she was pronounced dead from a myocardial infarction.

The E.R. nurses failed to assess fully and communicate to the physician the nature, duration and extent of the patient's chest pain, failed to ask for orders for enzyme tests, failed to question the order for early discharge without her being kept for observation and failed to access the nursing chain of command by going to a nursing supervisor.

DISTRICT COURT
JEFFERSON COUNTY, TEXAS
January 20, 2010

The jury in the District Court, Jefferson County, Texas ruled the E.R. nurses were 80% and the E.R. physician 20% liable for the patient's death and awarded $1,315,275 from the hospital as the nurses' employer in addition to $162,112 the family had already received from the E.R. physician as a pre-trial settlement.

The family's nursing experts placed a heavy weight of responsibility directly on the nurses to orchestrate and ensure proper care for this cardiac patient in the E.R. **Licatino v. Christus Health, 2010 WL 4388956 (Dist. Ct. Jefferson Co., Texas, January 20, 2010).**

Phenergan: IV Infiltration, Nurses Held Responsible For Loss Of Patient's Thumb.

The forty-seven year old diabetic patient was admitted to the hospital for complications of chronic pancreatitis.

An IV was started in his right wrist. It was checked fifteen minutes later by his nurse and found to be intact.

Seven hours later, at 2:35 a.m., he began to complain of pain. A combination of Demerol and Phenergan was started through the IV. Soon the patient began to report he was also having severe pain in his hand and that his hand had begun to swell. The nursing progress notes mentioned that the hand was painful and swollen when the IV was checked at 3:00 a.m.

The IV was removed forty-five minutes later. The pain and swelling persisted in the hand for another thirty-six hours. The physician brought in an orthopedist for a consult, who recommended transferring the patient immediately by ambulance to a nearby tertiary care center for surgery.

The surgeon had to amputate the thumb. The patient remained at that hospital twenty-four more days for additional surgical procedures.

The nurses allowed the Phenergan to infuse too rapidly through the IV in the patient's wrist, leading to extravasation into the surrounding tissue.

Then they failed to remove the IV and report the situation to the physician as soon as they should have.

SUPERIOR COURT
COFFEE COUNTY, GEORGIA
March 26, 2010

The jury in the Superior Court, Coffee County, Georgia awarded the patient $1,533,026 from the hospital. **Jackson v. Coffee Regional Med. Ctr., 2010 WL 4231489 (Sup. Ct. Coffee Co., Georgia, March 26, 2010.)**

Phenergan: IV Infiltration, Nurse Held Responsible For Complex Regional Pain Syndrome.

Following her hysterectomy the forty-seven year-old patient had an order for Phenergan 25mg prn for nausea.

When the medication was started the patient reported an immediate burning sensation from infiltration of the IV into her hand, along with pain, swelling and limitation of movement. She was diagnosed with complex regional pain syndrome which required a spinal cord stimulator for pain management. She has not returned to her former employment as a hair stylist.

The patient's expert witness testified that the nurse allowed the Phenergan to run too rapidly, and when the IV infiltrated the surrounding tissue it caused tissue damage.

The jury in the Court of Common Pleas, Cuyahoga County, Ohio awarded the patient $1,056,000 from the hospital. **Russo v. Southwest General Health Center, 2010 WL 4633450 (Ct. Comm. Pl. Cuyahoga Co., Ohio, October 6, 2010).**

Post-Surgical Care: Two-Person Assist Not Provided.

The Court of Appeal of Louisiana threw out a jury verdict in favor of the hospital and awarded the patient the maximum allowed in Louisiana, $500,000 in damages for pain and suffering.

The patient who weighed about 300 pounds was in the hospital recovering after bilateral knee replacement surgery.

One CNA tried to transfer her by herself from her wheelchair to the toilet without properly latching the riser seat to the toilet seat, and the patient fell. Two persons, using a gait belt, were absolutely necessary for this transfer, the Court said. **McGlothlin v. Christus St. Patrick Hosp., __ So. 3d __, 2010 WL 4628195 (La. App., November 17, 2010).**

Hoyer Lift: Aide Tried To Transfer Patient By Herself.

One nurses aide was attempting by herself to transfer a nursing home resident from his chair to his bed using a Hoyer lift.

The metal hook on the cradle bar somehow caught his eye. He had to be taken to the hospital where the eye was removed.

The resident signed an arbitration agreement when he was admitted, stating that neither he nor his estate could sue the nursing facility if he was killed or injured under their care.

He was ninety-one years old, had just had a stroke and was suffering from delusions.

He did not have the mental capacity to sign a binding contract. The arbitration agreement is null and void and his family can sue.

SUPERIOR COURT
PLYMOUTH COUNTY, MASSACHUSETTS
August 1, 2010

The jury in the Superior Court, Plymouth County, Massachusetts awarded $400,000 to the family, finding the facility liable for the loss of his eye but not liable for his death from sepsis seven weeks after he was admitted to the hospital.

The basis for the suit was that the aide was negligent in that she should not have attempted to transfer the patient by herself when she had been trained that a Hoyer-lift transfer requires two people. The aide was fired afterward and reported to the State Board of Health and her name was placed in the State registry.

It was alleged further that the facility itself was negligent for failing to train and supervise its staff adequately in the use of the Hoyer lift. **Owens v. Kindred Healthcare, Inc., 2010 WL 4231542 (Sup. Ct. Plymouth Co., Massachusetts, August 1, 2010).**

Alzheimer's: Assault On Another Nursing Home Resident, Lapses Found In Standard Of Care.

The standard of care requires a nursing facility to assess a potential resident fully and completely prior to admission to be certain that the facility will be able to meet the resident's needs.

If an adequate assessment of his condition had been done it would have been obvious that the facility could not meet the perpetrator's needs for one-on-one supervision, physical restraints and intensive psychiatric care.

Ideally a nurse should have been sent from the facility to the hospital to carefully assess the resident's suitability for placement in light of the facility's capabilities to meet its residents' safety needs, before the resident was accepted.

After he was admitted to the nursing home the nursing staff had the opportunity to review his medical records and observed his aggressive behavior.

The nurses could have seen to it that he got the one-on-one supervision that he required and then could have reported their concerns about his unsuitability for the unit to the director of nursing and the facility administrator.

COURT OF APPEALS OF TEXAS
November 4, 2010

A resident of the nursing home's Alzheimer's unit was ambulating through the dining room using her walker.

Suddenly and for no apparent reason a male resident of the same Alzheimer's unit grabbed her walker, turned it upside down and threw in on the floor.

The resident whose walker was taken fell, hit her head on the floor and later died from a subdural hematoma.

The deceased resident's family filed a civil lawsuit for wrongful death against the resident who assaulted her.

Later the family amended their lawsuit to include allegations against the nursing home itself for negligence for failing to evaluate the perpetrator prior to admitting him, failing to manage, restrain and evaluate him following his admission and for failing to protect the victim from the perpetrator.

The Court of Appeals of Texas looked carefully at the facts of the case and at the opinions of the expert witnesses who were prepared to testify on behalf of the family. The Court ruled that the family had grounds for their lawsuit against the nursing home.

Prior Aggressive Behavior Inadequate Assessment

The perpetrator had already been diagnosed with early-onset Alzheimer's before he was admitted to an acute care hospital following a seizure at home.

At the hospital he required physical restraints and one-on-one supervision by a personal sitter due to his aggressive and combative behavior.

When he came from the hospital to the Alzheimer's unit he continued to act out aggressively. It was only his second day out of the hospital on the Alzheimer's unit when he attacked and killed the other resident by seizing her walker from her.

No nursing home staff were on duty at the time in the dining room monitoring or supervising the other residents or keeping an eye out in particular for the perpetrator, when the tragic incident occurred. **Christian Care Centers, Inc. v. Golenko, __ S.W. 3d __, 2010 WL 4352731 ((Tex. App., November 4, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Child Abuse: Minor Gets Settlement From Caregivers Who Did Not Report.

The child, now six years of age, reportedly suffered an ongoing pattern of physical abuse at the hands of her adoptive parents which culminated in a serious head injury that has left her disabled and confined to a wheelchair.

For several years a nurse practitioner in her pediatrician's office treated her for burns, head trauma and chipped teeth, all possibly indicative of abuse. Until the child was finally hospitalized in a coma none of her caregivers reported her plight to the department of social services as was their legal responsibility. The nurse practitioner reportedly wrote a letter to the department for the adoptive parents advocating that they be allowed to keep the child in their custody.

The child's civil lawsuit in the Superior Court, Suffolk County, Massachusetts resulted in a $1,900,000 settlement from the nurse practitioner and the pediatrician. **Confidential v. Confidential, 2010 WL 4231545 (Sup. Ct. Suffolk Co., Massachusetts, July 1, 2010).**

Labor & Delivery: Nurses Advocated For Antibiotics, Ruled Not Negligent.

At thirty-six weeks the mother came to the hospital where her new daughter was to be delivered by the ob/gyn who had provided her prenatal care. Because the mother's labor was slightly premature the labor and delivery nurses contacted the ob/gyn to recommend antibiotics as a precaution against Strep infection.

The ob/gyn never ordered antibiotics, the mother never received any and the infant developed complications shortly after birth.

After the ob/gyn settled, the case against the hospital went to trial in the Circuit Court, Hancock County, Indiana. Without allowing the jury to deliberate, the judge dismissed the case, ruling that the nurses fulfilled their duty to advocate for the patient and were not negligent to assume the patient's ob/gyn had good reason not to order antibiotics, which the nurses themselves could not give without an order. **Ogle v. Hancock Regional Hosp., 2010 WL 4676325 (Cir. Ct. Hancock Co., Indiana, June 10, 2010).**

Emergency Room: Death Of Dehydrated Infant After Discharge Blamed On Nursing Negligence.

The mother brought her four year-old to the emergency room for symptoms of gagging and watery diarrhea.

The E.R. physician did not think the child was dehydrated. He prescribed Phenergan syrup for treatment of her nausea, told her mother to give her plenty of fluids and discharged her.

That night the child's condition worsened. She became lethargic and was not even able to hold her head up to take a drink. The diarrhea continued.

The mother called the hospital and spoke with a nurse. The mother claimed the nurse told her not to bring the child back to the hospital but instead to give the medication more time to work.

During the night the child's older brother found her in bed not breathing.

Discharge instructions are the responsibility of the hospital's nurses.

The nurses should have instructed the mother to bring her child back to the hospital if the child's condition worsened, that is, if the diarrhea persisted or the child became lethargic.

When the mother phoned the hospital that night, the nurse should have told her the same thing.

CIRCUIT COURT
JEFFERSON COUNTY, INDIANA
July 27, 2010

The child died. The autopsy identified dehydration from fluid volume loss due to diarrhea from enteric inflammation as the cause of death.

The family's lawsuit in the Circuit Court, Jefferson County, Indiana resulted in a judge's ruling finding only the hospital at fault and dismissing the E.R. physician and the manufacturer of the Phenergan syrup from the case.

The nurse's statement to the mother when she phoned in for advice was clearly erroneous, the judge ruled.

Earlier that day the E.R. nurses failed to carry out their responsibility to give complete and adequate discharge instructions to the mother, to bring the child back to the E.R. if her mental status changed for the worse or the diarrhea did not stop. **Ritch v. Bernard, 2010 WL 4676343 (Cir. Ct. Jefferson Co., Indiana, July 27, 2010).**