Neglect: Nurse Forcibly Gave Enema, Name Placed In Abuse Registry.

A resident of a long-term care facility had not had a bowel movement for several days. Facility policy called for a nurse to give him an enema.

His nurse asked him to lie in bed on his left side so she could proceed with his enema, but he got out of bed, refused to get back into bed and sat on the side of the bed with his feet firmly planted on the floor.

The nurse went out and told an aide to go to the room to help her. When the nurse returned the resident had wheeled himself to the bathroom in his wheelchair and the aide was helping him take down his pants so he could sit on the toilet and have a bowel movement on his own. The nurse chased him around the room, caught him and gave the enema while he was standing over the toilet. When he sat down and had his bowel movement blood dripped out of his rectum. The nurse went back to the nurses station and reportedly bragged that the patient had "fought like a bull."

The patient had to be taken to the hospital. His physician's assessment was that he was not injured but bled because he was on Coumadin and passed a hard stool.

Neglect means inattention to the physical needs of a patient or resident, including but not limited to toileting, bathing, meals and safety.

SUPERIOR COURT
SUSSEX COUNTY, DELAWARE
June 29, 2010

Although there was no evidence the enema injured the patient, the Superior Court, Sussex County, Delaware upheld the decision of the state Division of Long Term Care Residents Protection to place the nurse's name in the registry of persons found guilty of neglect of a vulnerable person in their care. **Sauers v. State of Delaware, 2010 WL 2625549 (Del. Super., June 29, 2010).**

Emergency Room: Communication Breakdown Leads To Patient Lawsuit.

The male E.R. patient had had an artificial urinary sphincter implanted surgically at the hospital. He had gone back to the same hospital one month later for a surgical modification, a constricting sleeve to correct urinary leakage. Two months after that he had gone back to the hospital for yet another adjustment.

Six weeks later he went to the same hospital again, this time to the emergency department, because of urinary retention.

He showed the E.R. personnel the medical information card that that same hospital had given him for his artificial urinary sphincter, just as he was instructed when he got it at the hospital.

Nevertheless, personnel in the emergency department tried to catheterize him without deactivating his artificial sphincter, causing a significant discharge of blood along with the urine.

After the bleeding alerted them that something was wrong a urologist was called in who quickly realized what the problem was and deactivated the device.

The Court of Appeals of Texas ruled that the patient's expert witness correctly outlined the standard of care and departures from that standard.

Effective Communication Is Necessary In the Emergency Department

Procedures were not in effect to ensure effective communication with a Spanish-speaking patient.

Regardless of any language barrier, after the patient showed them his medical information card which fully informed the E.R. staff about his particular medical situation and needs, that information was not shared among the nurses and physicians caring for him.

His chart from the hospital for his previous three admissions contained information that was obviously significant. However, his caregivers never looked up his prior chart before simply going ahead with a standard, routine medical intervention for his chief presenting problem. **Martinez-Partido v. Methodist Spec. Hosp., __ S.W. 3d __, 2010 WL 2838629 (Tex. App., July 21, 2010).**

Emergency Room: Court Finds EMTALA Violation.

The thirty-nine year-old patient came to the emergency room with abdominal pain, nausea and vomiting and said he had been constipated for four days.

He was given pain medication, an enema and manual disimpaction of his colon, but no lab tests or x-rays were done.

He was sent away in an ambulance at 12:40 a.m. The ambulance drove around to several relatives' homes who all refused to take him, returned him to the E.R. and then transported him to a nearby bed and breakfast. The bed and breakfast called 911 at 5:25 a.m. the same morning because he was vomiting blood. The same hospital discharged him again at 12:15 p.m.

The patient died that afternoon at a relative's home from purulent peritonitis caused by rupture of a duodenal ulcer.

The hospital chart itself showed that the patient was in severe pain and was vomiting blood. His respiration rate, hematocrit and white blood cell count were high and his red cell count and lymph percentage and urine output were low.

The patient was not stable at the time of discharge.

COURT OF APPEALS OF KENTUCKY
July 16, 2010

The Court of Appeals of Kentucky saw grounds for a lawsuit against the hospital by the family for violation of the US Emergency Medical Treatment and Active Labor Act (EMTALA).

The patient was discharged from the hospital in medically unstable condition which posed serious jeopardy to his health. The hospital had a legal responsibility to provide an appropriate medical screening and necessary stabilizing treatment, but failed to do so. **Thomas v. St. Joseph Healthcare, __ S.W. 3d __, 2010 WL 2812967 (Ky. App., July 16, 2010).**