LEGAL EAGLE EYE NEWSLETTER

February 2010 *For the Nursing Profession* Volume 18 Number 2

Patient's Fall: Nurse Ruled Negligent, Left Fall-Risk Patient Standing Alone With Walker.

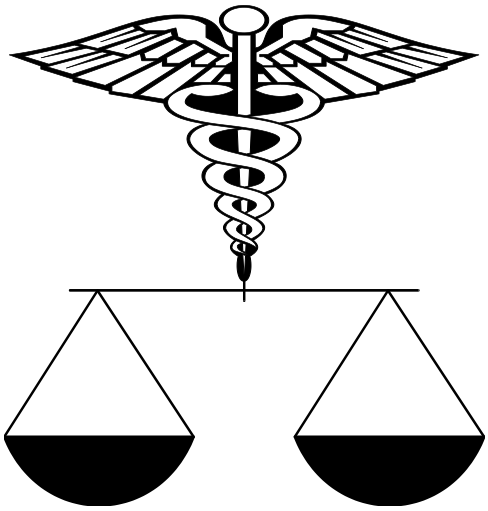
The sixty-five year-old patient had had femoral artery bypass surgery just a few days earlier. The procedure involved entering the abdominal cavity to create tunnels through the groin to link the descending aorta to the proximal femoral arteries, to improve circulation in his legs.

The med/surg nursing staff assessed his fall risk several days post-op as 60 on the Morse Fall Scale. The Morse scale takes into consideration the patient's history of falling, medical diagnoses, use of ambulatory aids, presence of an IV, gait and mental status.

Although he did not have a history of falling, the largest weighted numerical component of fall-risk assessment, and he was alert and oriented, his overall weakness after a recent major open abdominal procedure, impaired gait and use of a walker per orders from his physical therapist qualified him as a significant fall risk patient.

The nursing fall-prevention care plan included bed rails up, use of the walker and assistance to ambulate.

The walker was kept in the corner of the room where the patient could not reach it by himself from the bed. He had to ring for someone to bring his walker to the bedside and then provide him with assistance to stand up and ambulate where he wanted to go.



The negligence in this case, that is, violation of the standard of care by the patient's nurse, falls within the sphere of common knowledge and would be obvious to any lay person sitting on a jury.

The nurse failed to attend to the needs of a known high-fall -risk patient who needed assistance to walk even short distances with a walker.

COURT OF APPEAL OF CALIFORNIA
December 22, 2009

The patient rang for a nurse to help him to the bathroom. A nurse came to the room, got the walker, brought it to the bedside, lowered the bed rails, helped him stand up, then told him he had to go and do something else and left him standing there.

After fifteen minutes standing and waiting, the patient took one step forward, lost his balance and fell backward, then lay there for two hours on the floor before he was found. The patient had a compression fracture in his back at the T-12 vertebral level.

The Court of Appeal of California accepted the patient's allegations of negligence under the "common knowledge" exception to the general rule that expert testimony is required as to the caregiver's standard of care.

The Court, however, dismissed the patient's allegation that the nurse tried to cover up his own negligence by giving the patient morphine, not for pain but hoping it would make him forget what had just happened, after he came back and found his patient on the floor

The nurse candidly charted what really happened, that he left his patient standing alone and then came back and found him on the floor, which tended to negate any intent to stage a cover-up. **Massey v. Mercy Medical Center, 180 Cal. App. 4th 690, 103 Cal. Rptr. 3d 209 (Cal. App., December 22, 2009).**

www.nursinglaw.com/feb10mtg6.pdf

February 2010

New Subscriptions See Page 3

Prenatal Care: Student Nurse, Signs Of Fetal Distress Ignored.

The thirty-five year-old patient, pregnant for the first time, came to the clinic for a prenatal visit at thirty-three or thirty-four weeks.

She was seen in the clinic only by a student nurse.

The patient reportedly told the student nurse she had noticed a reduction in fetal movement over the previous few days.

The student nurse conducted a comprehensive exam. She documented elevated blood pressure, proteinuria, pitting edema from the mid-calf down and the fact the fetus was in breech presentation.

The student nurse also charted that she was unable to detect a fetal heart rate.

The student nurse relayed her findings to the clinic's nurse midwife.

The nurse midwife did not examine the patient herself or follow up with a non-stress test the same day.

A non-stress test the same day would have been non-reassuring. That most likely would have led to a decision to do the cesarean that same day.

SUPERIOR COURT
BRISTOL COUNTY, MASSACHUSETTS
August 29, 2008

The parents' case filed in the Superior Court, Bristol County, Massachusetts resulted in a $5,000,000 settlement.

The mother did have a non-stress test, but not until the next day. The baby was quickly delivered by cesarean section, but not without profound neurological deficits. Now eleven years old, the child is significantly delayed, suffers from quadriparesis and has a j-tube. **Confidential v. Confidential, 2008 WL 7070104 (Sup. Ct. Bristol Co., Massachusetts, August 29, 2008).**

Pediatric Intensive Care: Inexperienced Nurse Ignored Her Pager.

The five month-old had been diagnosed at birth with tetralogy of Fallot and was a frequent patient at the hospital for heart and kidney problems.

The child's mother brought her to the hospital's renal clinic because she was vomiting. The child's oxygen saturation was low and she was having respiratory difficulty, so she was admitted to the hospital.

Her care was assigned to a team consisting of a third-year resident physician, two interns and a recent nursing school graduate who was still orienting.

The nurse was a recent nursing school graduate who was still in the orientation phase of her employment at the hospital.

She was assigned to carry the alarm pager but never responded to the alarm when the patient's mother noticed that the child had stopped breathing.

COURT OF COMMON PLEAS
PHILADELPHIA COUNTY, PENNSYLVANIA
November 10, 2009

The parents' lawsuit alleged the hospital was negligent to assign inexperienced personnel to care for an infant with complicated congenital medical issues who was in acute respiratory distress.

The jury in the Court of Common Pleas, Philadelphia County, Pennsylvania returned a verdict of $1,223,750. The verdict expressly assigned 15% of the liability for the child's death to the graduate nurse who failed to respond to the page and split the rest of the verdict among the three physicians. **Kyei v. Copelovitch, 2009 WL 5207357 (Ct. Comm. Pl. Philadelphia Co., Pennsylvania, November 10, 2009).**

Foley Catheter Dislodged: Large Verdict For The Patient's Estate.

The sixty-two year-old patient was admitted to the nursing home in a comatose state after having suffered two strokes.

Ten days after he arrived his penis began bleeding heavily. He was rushed to a nearby hospital's E.R.

The assessment at the hospital was traumatic injury from a Foley catheter. The physician also diagnosed urosepsis, low blood pressure and dehydration.

The patient died the next morning in the hospital.

The only plausible explanation for the patient's traumatic injury is mishandling of the patient while he was being turned by the nursing home's care staff.

CIRCUIT COURT
MARION COUNTY, ALABAMA
June 18, 2009

The family's lawyers presented expert testimony from a forensic pathologist. His opinion was that the trauma came from forcible pulling of the Foley catheter bulb through the patient's urethra. That had to have happened while he was being turned by the nursing home's nurses aides.

The family's nursing experts went on to fault the nursing home for failing to train its staff to secure the Foley tubing to the patient's leg to prevent traction being applied and for failing to instruct the aides in proper technique for turning a comatose patient with a Foley catheter.

The nursing home's medical experts disputed whether the injury, as opposed to his underlying medical issues, was the actual cause of the patient's death.

The jury in the Circuit Court, Marion, County Alabama accepted the family's experts' version of the facts and awarded the family $2,500,000. **Rhodes v. GGNSC, 2009 WL 4932458 (Cir. Ct. Marion Co., Alabama, June 18, 2009).**

Dementia Care: Window Should Not Have Been Left Open.

The patient was housed in a special dementia-care unit on the second floor of the building.

To reduce the risk of elopement the doors to the unit were kept locked and the elevator required a pass key to operate.

Resident Had Tried For Three Years To Open the Doors and Windows

The resident's elopement attempts were well known to the facility's staff.

On a particular day in June she made yet another attempt, this time through a window left open on the dementia unit. She fell out and sustained numerous fractures, dislocations, cuts and bruises.

The jury in the Circuit Court, Vanderburgh County, Indiana returned a verdict of $276,164 against the nursing facility in the resident's favor.

With her history of elopement attempts this resident required close supervision around an open window. Even if she seemed calm enough staff should have expected she could make her move at any time. Or, better, the window should have been closed and locked. **Ashby v. Beverly Healthcare, 2009 WL 4932578 (Cir. Ct. Vanderburgh Co., Indiana, September 1, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

Published monthly, twelve times per year.
Mailed First Class Mail at Seattle, WA.

E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
PO Box 4592
Seattle, WA 98194–0592
Phone (206) 440-5860
Fax (206) 440-5862
kensnyder@nursinglaw.com
www.nursinglaw.com

Asthma: Heavily Sedated Patient Dies, Family Obtains Settlement.

The twenty-seven year-old asthmatic patient came to the E.R. for an upper respiratory infection, was sent home and was sent back to the same E.R. several days later by her doctor with shortness of breath, wheezing, non-stop cough, chest pain and tachycardia.

The patient was admitted to the hospital and was started on several IV medications which can produce CNS and respirator depression, including Dilaudid, Ativan and Benadryl.

The nurses charted she was getting adequate pain relief and relief from anxiety with her medications. The physician added po anti-depressant trazodone and po anti-convulsant Neurotonin to the list of medications she was getting.

A respiratory therapist noted diminished breath sounds, expiratory wheezing, labored breathing and oxygen saturation of only 92% after giving the patient a breathing treatment.

The patient was found unresponsive by her nurse eighty minutes after IV push doses of Dilaudid and Ativan.

The patient received an additional 4 mg of Dilaudid IV and 4 mg of Ativan IV.

The patient was not checked for eighty minutes.

A nurse found the patient seated in her bed unresponsive. A code was called but the patient was pronounced dead.

SUPERIOR COURT
SAN DIEGO COUNTY, CALIFORNIA
October 14, 2009

Even though there were discrepancies between the coroner's report and the family's private pathologist's toxicology findings as to the cause of death, the family got a settlement of $1,175,000 for their lawsuit filed in the Superior Court, San Diego County, California. **Confidential v. Confidential, 2009 WL 4916568 (Sup. Ct. San Diego Co., California, October 14, 2009).**

Fall: Hospital Bed Wheels Defective.

After hip surgery the patient got up and used the restroom by herself. When she tried to get back in bed the bed rolled away and she fell and tore her rotator cuff.

The jury heard testimony from the patient's roommate who overheard a housekeeper tell a nurse beforehand the defective bed did not belong on the unit.

The jury's verdict discounted the patient's damages by 40% for the patient's own negligence. The judge in the Superior Court, Lake County, Indiana ruled the case was not a medical malpractice case and nursing experts were not necessary. **Sanders v. St. Catherine Hosp., 2009 WL 4932593 (Sup. Ct. Lake Co., Indiana, July 10, 2009).**

Emergency Room: Nurses, Physicians Followed Standard Of Care With Obstetric Patient.

The Court of Appeal of California endorsed the decision of the judge in the Los Angeles County Superior Court to dismiss the parents' lawsuit against the hospital for the stillbirth of their child.

The Court of Appeal agreed there was no deviation from the standard of care by the hospital's nursing or medical staff.

Sequence of Events

The mother and father arrived at the emergency department around 9:10 or 9:15 p.m. She was nine months pregnant, was cramping and thought she might be in labor.

Although she was already pre-registered for delivery in the labor and delivery department, about twenty minutes went by while she filled out new admission paperwork for the emergency department.

Blood began running down her leg at 9:40 p.m. She was immediately triaged by an E.R. nurse and then rushed to labor and delivery, arriving at 9:48 p.m.

The labor and delivery nurses phoned the patient's obstetrician. He ordered an ultrasound.

The nurses began listening for fetal heart tones and got a sonogram. A labor and delivery nurse phoned the obstetrician back at 10:00 p.m. to report there was no discernable fetal heart beat, while another labor and delivery nurse got the emergency room doctor to come to the unit.

The mother spontaneously delivered a stillborn baby at 10:03 p.m. It was apparent at that time, and verified later by the autopsy, that a complete placental abruption had occurred. The patient's obstetrician finally arrived at 10:30 p.m.

The Court accepted the hospital's expert's testimony that attempting a rush cesarean delivery in the emergency department is in itself very risky and is rarely the preferred course of action.

Further, reviewing the record and the autopsy report with 20/20 hindsight, the hospital's expert was right that no error or omission by the hospital's personnel caused the placental abruption which was the fundamental reason for the unfortunate outcome. **Walker v. Pacific Hosp., 2010 WL 7125 (Cal. App., January 4, 2010).**

Liability for malpractice requires proof of deviation from the standard of care. It takes more than just an unfortunate outcome.

The standard of care was correctly stated by the hospital's expert witness, a board-certified emergency medicine specialist.

The patient's presenting symptoms did not indicate the need for an emergency response when she first arrived.

In the case of an expectant mother with more than twenty weeks gestation, the accepted course of action for complaints of abdominal cramping is to notify the labor and delivery department of the mother's presence and to ask the patient to make herself comfortable in the E.R. until someone from labor and delivery is able to come for her.

Once this patient did start bleeding, the hospital's emergency department's nursing and medical personnel responded rapidly and appropriately.

Unfortunately, at that point there was no effective way to have delivered the fetus before the placental abruption caused the child to come out stillborn.

CALIFORNIA COURT OF APPEAL
January 4, 2010

Pitocin: Labor & Delivery Nurse Violated The Standard Of Care.

During the night the mother's contractions were coming too frequently so the Pitocin was stopped at 3:20 a.m.

Then the fetal heart rate became tachycardic and variable decelerations began to be seen, a pattern that continued for more than two hours until 5:30 a.m. when the attending physician, an obstetrician from Turkey in his first year of residency at the hospital, ordered the Pitocin re-started.

The patient's labor and delivery nurse would later testify in court she knew it was wrong to re-start the Pitocin under these conditions, but she did it anyway.

The nurse went on to agree with the patient's nursing expert that she should have refused to re-start the Pitocin and should have gone to her nursing supervisor. Her supervisor then could have gone up the hospital's chain of command to get a more senior and more seasoned physician to review and most likely overrule the attending resident's decision.

Even if it is assumed the labor and delivery nurse did violate the standard of care, there is no proof that her errors or omissions had any effect on the outcome.

The labor and delivery nurse is entitled to be dismissed from the case.

UNITED STATES DISTRICT COURT
ILLINOIS
January 6, 2010

The US District Court for the Northern District of Illinois nevertheless dismissed the labor and delivery nurse from the case.

The experts pinpointed not starting the cesarean until 7:45 a.m., after the fetus was already deceased, as the cause of the bad outcome. No evidence was offered to the judge that the nurse's failing to advocate for her patient would have resulted in the physicians moving ahead more quickly. **Maldonado v. Mt. Sinai Hosp., 2010 WL 63986 (N.D. Ill., January 6, 2010).**

Pitocin: Jury Rules Hospital's Nurses 100% At Fault For Baby's Death.

The patient came to the hospital's labor and delivery department at 10:00 a.m. and said she had been having labor contractions since 3:00 a.m. along with some bloody discharge.

The first nursing assessment on the labor and delivery unit with the monitor showed a fetal heart beat that was non-reactive and non-responsive to scalp stimulation. A prolonged fetal heart rate deceleration reportedly occurred at 10:42 a.m. lasting three to four minutes.

The nurses reported these findings to an obstetrician who ordered the patient admitted for induction of labor.

Despite non-reactive fetal monitor tracings and intermittent fetal heart rate decelerations, the labor and delivery nurses continued the Pitocin for more than five hours.

DISTRICT COURT
CLARK COUNTY, NEVADA
June 1, 2009

At 4:00 p.m. the fetal heart rate dropped to 40 and then fetal heart tones were lost altogether. The infant was delivered by cesarean in cardiac arrest with a cord pH of 6.8.

The jury in the District Court, Clark County, Nevada returned a verdict which expressly found the hospital 100% at fault and let the obstetrician walk away.

The hospital was held liable as the employer of the labor and delivery nurses who started and continued the Pitocin notwithstanding the physiologic findings indicating fetal distress.

The hospital itself was also faulted for not having explicit guideline parameters in place which would have contraindicated the use of Pitocin under these circumstances. **Benitez-Cordova v. Mayes, 2009 WL 5449875 (Dist. Ct. Clark Co., Nevada, June 1, 2009).**

Emergency Room: Nurse's Care Of Dog Bite Victim Met The Standard Of Care.

The patient had to return to the E.R. the next day and be admitted for surgical drainage of an infected abscess at the site of a dog bite.

Even with the most appropriate initial wound care in the emergency department it is not uncommon in dog-bite cases for the patient to have to return to the emergency department for treatment of an infection.

The nurse's discharge instructions fully complied with the standard of care.

The patient was instructed how she should care for her sutured and bandaged wounds, to take her antibiotic and to return if she saw signs of infection or had a reaction to the antibiotic.

NEW YORK SUPREME COURT
APPELLATE DIVISION
January 21, 2010

The New York Supreme Court, Appellate Division, accepted the hospital's medical expert's testimony that infection is not an uncommon development with dog bites, even with the best of medical care.

Further, the E.R. nurse gave the patient discharge instructions that met the standard of care for an E.R. nurse.

Nurse Should Have Had the Patient Sign the Discharge Instructions

The nurse neglected to have the patient sign the copy of the discharge instructions retained in the chart. It would have been better if she had, but it did not make her or the hospital liable. **DeLorenzo v. St. Clare's Hosp., __ N.Y.S.2d __, 2010 WL 184217 (N.Y. App., January 21, 2010).**

Sexual Abuse: Drug/Alcohol Rehab Unit Ruled Not Liable.

The Court of Appeals of Washington ruled that an acute care hospital's inpatient chemical dependency unit is not liable for payment of damages to a female former patient who had sexual relations on the unit with a male staff nurse.

The lawsuit is still pending against the now-former nurse from the hospital.

The nurse reportedly began flirting with her soon after she checked herself in for inpatient alcoholism treatment. They met and kissed in a storage room and on one occasion he got in bed with her in her room. They were supposed to meet in a motel, then at her house after she was discharged, but neither rendezvous took place and the relationship went no further.

The former patient filed a complaint with the hospital administration, which resulted in the nurse being forced to resign, then sued for damages.

This is not a case of a disabled, helpless or vulnerable patient being molested by a staff member.

This adult patient, a voluntary admit at the facility, voluntarily engaged in consensual sex with a nurse.

COURT OF APPEALS OF WASHINGTON
December 22, 2009

The court said the facts of this case are very different from other cases where institutions are held responsible for helpless, vulnerable adults being molested against their will by care-giving staff.

As far as the hospital's liability is concerned, the nurse had no history of sexual misconduct at this hospital or at any previous employer. The patient was not gravely disabled, helpless or vulnerable. There was no legal duty for the hospital to protect this patient from the consequences of her own actions. **Kaltreider v. Lake Chelan Comm. Hosp., __ P. 3d __, 2009 WL 4912642 (Wash. App., December 22, 2009).**

Diversion: Court Says Board Had Grounds To Impose Remedial Plan.

The nurse's employer, a long-term nursing care facility, supplied the State Board with a long list of discrepancies in the nurse's administration and documentation of narcotics.

Some of her patients who had narcotics charted were given UA's which showed no narcotics in their systems.

No Direct Proof of Diversion

Even though there was no direct proof the nurse had ever diverted narcotics for her own consumption, the Court of Appeal of Louisiana endorsed the State Board's imposition of a corrective plan which included:

Suspension of her license;

Psychological and chemical dependency assessment;

Strict adherence to treatment recommendations;

If found to be chemically-dependent, three year's participation in the Recovering Nurse Program;

Payment of a fine and costs.

The rationale was simply that the nurse had demonstrated she was incompetent to provide safe and effective nursing care. **Lewis v. State Board of Nursing, 2009 WL 4981290 (La. App., December 23, 2009).**

This nurse charted that she twice gave 4 mg of morphine to a patient who was only supposed to get 1 mg.

That fact alone supports the Board's decision to suspend the nurse's license and to impose certain conditions on her getting it back, on the basis that she is not able to practice safely and effectively as a nurse.

COURT OF APPEAL OF LOUISIANA
December 23, 2009

Sleep Deprivation: Court Nixes Night Nurse's Disability Discrimination Lawsuit.

A night-shift nurse assigned to the hospital's cardiac step-down unit sometimes was in charge, but on the night in question was scheduled as a staff nurse.

When he came on duty he reported to his supervisor that he was ill with a migraine headache and was having heart palpitations. He wanted to go to the E.R. for treatment but was ordered instead to start working his assigned shift on the unit.

During the night he provoked a physical altercation with a co-worker and then left the unit early in the morning without completing his charting. He was fired.

Being able to sleep only two to four hours a day lacks the kind of severity required for an ailment to rise to the level of a substantial impairment of a major life activity.

Simply put, even though the nurse's sleep impairment was corroborated by his personal physician's testimony, it is not a disability under the Americans With Disabilities Act.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
December 22, 2009

The US Court of Appeals for the Sixth Circuit threw out the disability discrimination lawsuit the nurse filed against his former employer.

Sleep deprivation from being able to sleep only a few hours on days he worked nights, even if it did explain his unacceptable behavior, is not a disability.

Not having a legally-recognized disability, the nurse was not able to sue for disability discrimination. **Simpson v. Vanderbilt Univ. Hosp., 2009 WL 4981684 (6th Cir., December 22, 2009).**

Nurse As Patient's Advocate: No Liability Found For Patient's Death.

The patient came to the emergency room at 5:20 p.m. with severe chest pain and feelings of heaviness, weakness and dizziness.

The physician ordered a cardiology consult and a chest CT scan and started the patient on Heparin.

By the time the CT report arrived in the E.R. at around 10:30 p.m. the only one caring for the patient was the LPN on duty. She did not understand the CT report, so she phoned the RN on duty in the critical care unit and read it to her over the phone.

Once informed of the dire seriousness of the possible aortic dissection indicated by the CT report, the LPN made arrangements to get the patient into the critical care unit.

Then the LPN began making a series of calls and call-backs to the E.R. physician, cardiologists and thoracic surgeons, in the hospital or at home who practiced with outside medical practice groups, all of whom seemed to think it was some other person's, a different service's or another specialty's problem.

The patient coded at 3:42 a.m. and died at 4:06 a.m.

The records contain notations of a long series of calls and follow-up calls by the E.R. LPN to get someone to come in to see her patient and do whatever it was that needed to be done.

CIRCUIT COURT
ETOWAH COUNTY, ALABAMA
February 27, 2009

The jury in the Circuit Court, Etowah County, Alabama returned a defense verdict, despite the testimony of the family's nursing expert that the LPN was inexperienced and should not have been assigned to this patient's care. **Estate of Hamrick v. Ferguson, 2009 WL 4932521 (Cir. Ct. Etowah Co., Alabama, February 27, 2009).**

Patient Fall: Bed Alarm Not Activated, Large Verdict For Negligence.

The patient was admitted to the hospital's ICU after a mild stroke which left him with some weakness on the left side of his body.

The ICU bed was equipped with a bed alarm to alert the nurses if the patient tried to get out of bed.

After receiving sleep medication the patient became disoriented. Apparently thinking he was still at home, he tried to get out of bed by himself to go to the bathroom, fell and injured his hip.

The jury in the Superior Court, Providence County, Rhode Island, awarded $4,990,000 based on testimony that the ICU nurses were negligent for failing to turn on the bed alarm and that the hospital was negligent for failing to train the nurses in the care of high-risk fall patients. **Villegas v. Roger Williams Med. Ctr., 2009 WL 5416631 (Sup. Ct. Providence Co., Rhode Island, June 1, 2009).**

Fall From Chair: Jury Finds No Negligence.

The eighty-six year-old patient was in the hospital recovering from a cardiac procedure.

Her fall assessment was that she was a high fall risk. She was left alone sitting in her chair next to a tray with a wash bowl with instructions from her nurse to wash herself. When the nurse returned she was on the floor with a broken hip. She died several months later in a nursing home from complications from the hip fracture.

The jury in the Court of Common Pleas, Mahoning County, Ohio accepted testimony from the nurse that they correctly assessed her as capable of following instructions and saw to it she had her call bell within reach. **Carsonie v. St. Elizabeth Hosp., 2008 WL 6101407 (Ct. Comm. Pl. Mahoning Co., Ohio, December 12, 2008).**

Patient Fall: Court Reviews Charges Of Negligence.

The patient was admitted to the nursing home following a stroke.

She fell or was dropped during a transfer from her bed to a wheelchair and sued the nursing home for negligence.

The local parish district court judge believed it was simply an unavoidable accident and dismissed the lawsuit.

The Court of Appeal of Louisiana, however, ruled there were grounds upon which a jury could find the nursing home guilty of negligence and sent the case back to be scheduled for a civil jury trial in which the patient will have her day in court.

Maximum Assistance Required

The patient's care plan at the time called for maximum assistance during transfers. At this facility that phrase meant that the patient was not expected to bear weight on either or both of her legs during a transfer maneuver. If one particular person had the strength to lift the patient, that one person would suffice.

After the fact the patient's care plan was changed to two-person assistance, but that was not relevant before the fact.

The one person attempting the transfer in question was pregnant and weighed only 103 lbs., that is, she was significantly smaller than the patient herself. Also, she was not at the time certified as a CNA, had not yet been trained in transfer techniques and apparently did not appreciate the risk of the patient falling.

Boot Not Removed From Foot

The patient wore a boot on one foot for pressure relief while in bed.

Although it was not correct technique in this case to allow the patient to bear weight on either foot, if a patient is to bear weight on one foot during a transfer, according to the Court, the footwear on that foot has to be appropriate for supporting the patient without slipping during the transfer, and if not it has to be removed for the transfer.

The boot was not removed from the patient's weight-bearing foot, a fact which the Court presumed contributed to the fall. **Repp v. Sherwood Manor, 2009 WL 4981908 (La. App., December 23, 2009).**

Choking: Nursing Home Staff Ruled Not Liable For Patient's Death.

The patient, only in her late thirties, had to be admitted to a nursing home following a severe stroke. She was known to suffer from dysphagia and hemiparesis as *sequelae* of her stroke.

The patient refused to eat her meals in the dining room under staff supervision, even after being warned repeatedly of the risks involved in eating alone in her room.

The family also kept bringing in solid foods which were not appropriate, at the patient's request, despite the fact the patient was being provided a soft mechanical diet per the doctor's orders by the nursing facility's dietary department.

Nevertheless, nursing home staff routinely made it a point to check on her while she was eating alone in her room.

One day during the lunch hour she was found unresponsive. Staff immediately did the Heimlich maneuver to remove a piece of bread stuck in her airway, then suctioned her, while emergency paramedics who had been called were on their way to take her to the hospital.

The nursing supervisor on duty at the time reportedly checked the call button right afterward, found it was fully functional and made note of that fact on the incident report she wrote up and submitted to the state department of health.

The patient was intubated at the hospital for twenty-four days, then weaned from the ventilator. Being a lifelong smoker who refused to quit, she needed a tracheostomy through which to breathe and had to come back to the hospital more than fifty times for tracheostomy emergencies and surgical revisions.

The jury in the Superior Court, Middlesex County, Massachusetts returned a defense verdict in favor of the nursing facility. The jury was reportedly influenced by a continuing history of patient noncompliance long after the events in question and by doubts that the choking episode at the nursing home was a factor in her death five years later. **Sisko v. Sunbridge Healthcare, 2009 WL 5416520 (Sup. Ct. Middlesex Co., Massachusetts, August 11, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Purplish Ecchymoses: US Appeals Court Rules Agency Failed To Look At All The Evidence, Reverses Civil Monetary Penalty.

An eighty-six year-old patient was admitted to a skilled nursing facility (SNF) with multiple diagnoses including arteriosclerotic heart disease, hypertension, congestive heart failure, COPD and Alzheimer's.

Two days after admission she had a stroke. She was taken to the hospital, started on Plavix and aspirin and transferred back to the SNF.

During the hospital stay a physician noted the presence of multiple ecchymoses on the patient's body. A nurse from the SNF reportedly overheard a comment by the physician that he had never seen another case quite like it.

The nurse relayed this to her director. The director phoned the physician for an explanation but they never heard back from him.

After the patient passed away a few days later the family filed a complaint with the state. State investigators interviewed the nurse who had been at the hospital and several CNA's and decided that the ecchymoses were bruises from physical abuse. The SNF was hit with a $3,500 per day penalty for immediate jeopardy.

Immediate jeopardy is defined by Federal regulations as a situation in which the provider's non-compliance with patient-care standards has caused, or is likely to cause, serious injury, harm, impairment or death to a resident.

Investigators Never Consulted the Physician

The SNF nurse mistook the physician's comment at the hospital as veiled innuendo that the patient was a victim of abuse. The physician's actual testimony, which was never heard until the SNF filed its appeal in Federal court, related the purplish skin discoloration to the blood-thinning medications, Plavix and aspirin.

The US Court of Appeals for the Eighth Circuit ruled it was pure speculation for the investigators to jump to the conclusion that a condition of immediate jeopardy to patient safety existed at the SNF without delving into what was really going on with the patient medically. The SNF's DON could have been more conscientious following up with the physician, but that did not justify the harsh penalty. **Grace Healthcare v. US DHHS, 589 F. 3d 926 (8th Cir., December 21, 2009).**

Labor Law: Nurse Fired For Criticizing Staffing, Court Sees Unfair Labor Practice By Hospital.

An RN who was a union steward at the hospital was fired shortly after making public statements criticizing nursing workloads at the hospital.

At the time the nurses' union was involved with the hospital in what the US Court of Appeals for the Ninth Circuit described as an "ongoing labor dispute" over working conditions.

The nurse filed a complaint with the National Labor Relations Board (NLRB) that her firing was an unfair labor practice, that is, that the hospital violated rights guaranteed to her as a private-sector employee under the US National Labor Relations Act (NLRA).

The NLRA says that it is an unfair labor practice for an employer to interfere with, restrain, coerce or discriminate against an employee to discourage union membership or participation.

During a labor dispute an employee associated with the union is allowed to make disparaging public statements about working conditions, so long as the statements are not disloyal, reckless or maliciously untrue.

It is an unfair labor practice for an employer to take action against an employee for exercising his or her rights under the NLRA.

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT
November 17, 2009

An employee, on the other hand, has no right to make statements, even if they are true, which are intended to interfere with the employer's ability to conduct legitimate business operations, statements which are known to be false or statements which reveal confidential information.

In this case the evidence was clear, the Court of Appeals said, that the timing of the nurse's firing was intended as an anti-union intimidation tactic.

However, at the same time the NLRB did not believe it was necessary or appropriate to force the hospital to have to email each and every employee to notify them that the hospital had been found guilty by the NLRB of an unfair labor practice for the way the nurse was treated. **Nevada Service Employees Union v. NLRB, 2009 WL 4894275 (9th Cir., November 17, 2009).**