LEGAL EAGLE EYE NEWSLETTER

February 2011 *For the Nursing Profession* Volume 19 Number 2

Post-Surgical Nursing Care: Court Sees Grounds For Patient's Negligence Lawsuit.

The patient's underwent a nine-hour thoracic surgical procedure for mitral valve repair.

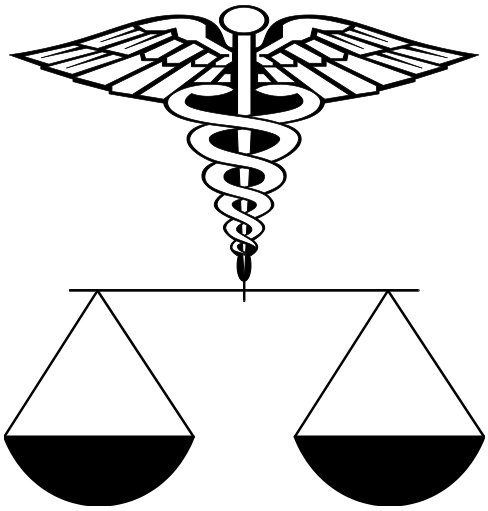
During the procedure, which normally lasts around three hours, circulation was compromised to the lower leg on the side of the body where the femoral arterial and venous cannulas were inserted to route blood to the heart/lung machine.

Compartment syndrome is a known risk that can come with lengthy cannulation of the femoral circulation, leading to ischemia, muscle damage, limb amputation and even death.

The patient did not do well in his initial recovery period. He stayed on the ventilator with high O_2 concentration for blood clots in his lungs and gained about forty pounds of fluid. Elevated creatinine pointed to renal failure.

Two days after surgery the patient, although still under heavy sedation, was pointing to his leg and trying to communicate something to his nurse and to his wife who was at the bedside.

The nurse would not give him a pencil and paper to write. She just assumed the problem was a cramp in his leg and began massaging his calf. She noticed that the calf was harder than a normal leg. It was also clear from his facial expression that the patient was in a lot of pain.



When the nurses checked for pedal pulses post-operatively they found them diminishing over time.

Later the patient tried to communicate that he was in pain. His foot was cold and his lower leg was turning blue.

Major damage to the leg could have been avoided if the nurses had contacted the physician.

COURT OF APPEALS
OF NORTH CAROLINA
January 4, 2011

Two days before the pedal pulses disappeared altogether the nurses began to notice diminishing strength of the pedal pulses in the right foot. Some days there was also no documentation at all of the pulses being checked during the p.m. hours, even though the surgeon had written orders for circulation checks every four hours.

Family members noticed the patient's foot was cold and his lower leg was blue. The nurse told them that was normal after heart surgery.

During the night the nurse noticed there was no pulse at all in the right foot. The nurse called the surgeon's physician's assistant, who relayed the message to the surgeon. The surgeon realized it was compartment syndrome and came in and performed a fasciotomy, but not before significant permanent damage had been done to the muscles of the patient's lower leg.

If the nurses had been checking the patient as closely as they should have, and had reported the signs to the surgeon, compartment syndrome could have been discovered and acted upon almost two days sooner. The Court of Appeals of North Carolina ruled the patient had grounds to sue for nursing negligence. **Perry v. Presbyterian Hosp., __ S.E. 2d __, 2011 WL 13935 (N.C. App., January 4, 2011).**

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February 2011

New Subscriptions See Page 3

Patient's Fall: Court Finds Evidence Of Negligent Care.

The patient was a seventy-two year-old military veteran 100% disabled from a depressive neurosis.

His medical diagnoses included dementia, schizophrenia, organic brain syndrome, diabetes and COPD. He was verbally and physically aggressive toward his caregivers.

He was being treated in the VA for a blood clot in his leg following hip-repair surgery. For some time he had required full assistance with his activities of daily living and then became completely immobile in bed after he broke his hip.

One day the nurses noticed a bruise on his arm and notified a physician. The patient told the physician he had fallen in the bathroom and bruised his arm, although he wore adult diapers, was bathed in bed and never actually used the bathroom. An x-ray showed a fracture of the left humerus.

The next day a nurse practitioner noticed his left lower leg was also bruised. An x-ray showed fractures of the left tibia and fibula.

After he saw the patient five days later his attending physician wrote a progress note stating, "He did NOT fall ... this is documented by all the nurses."

Court Finds Sufficient Evidence The Patient Did Fall

The patient had had a chest x-ray four months earlier, which showed no upper extremity fracture, but the x-ray right after the bruises appeared showed a fracture. Both the arm and leg fractures were consistent with traumatic injury.

The patient's wife testified he told her he was dropped. Even with his mental deficits, the patient's statement was entitled to some weight. The wife also testified she had seen him moved by one person using a lift and at times by two persons not using a lift, just grabbing body parts.

The nursing care flow sheets and other documentation for the relevant time period, right before the bruises were discovered, did not show that the care plan was being followed for two-person transfers with a mechanical lift. There was no nursing care documented on the night shift the night before, which pointed to substandard care. **Houser v. US, 2010 WL 5476695 (D.S.D., December 30, 2010).**

There may be situations where fractures occur in nursing care without negligence by a caregiver, but this is not such a case.

It is true that the patient's age and having taken valproic acid may account for some weakness in his bones.

However, considering the patient's statement that he was dropped, the location of the impaction fractures and the evidence concerning the patient transfer and charting practices around the time the injuries were discovered, it can be said the patient's injuries were not caused by weak bones.

The weight of the evidence, taken as a whole, supports a decision that negligence by one or more of his caregivers caused this patient's injuries.

The care plan called for transfer by two staff people using a mechanical lift. The flow sheets and other records do not substantiate the care plan being followed during the relevant time period, right before the bruises were found.

Although the investigation failed to pinpoint the cause, it is fair to conclude the injuries were the result of an improper transfer or a drop.

UNITED STATES DISTRICT COURT
SOUTH DAKOTA
December 30, 2010

Patient's Fall: Jury Faults Transfer To Assisted Living.

The elderly nursing home resident suffered from dementia, Parkinson's disease and degenerative arthritis.

Her annual Minimum Data Set assessment determined that she still required the services of the nursing home.

But then issues came up with her Medicaid reimbursement, followed within two weeks by a new assessment which concluded she was now ready for transfer to an assisted living facility.

She, her family and her physician protested the plan to transfer her, but she was transferred nonetheless.

Four days after moving into the assisted living facility she fell flat on her face and fractured her nose.

She had to be taken to the E.R. for her injury. Then she was moved back into the same nursing home she had just left.

The patient may have been moved to try to free up a bed for another patient whose care would be reimbursed at a higher rate.

COURT OF COMMON PLEAS
SPARTANBURG COUNTY
SOUTH CAROLINA
August 27, 2010

The jury in the Court of Common Pleas, Spartanburg County, South Carolina awarded the patient $50,000 against the nursing home which remained a defendant in the lawsuit after the assisted living facility settled out of court.

The patient's attorney argued to the jury that the move to assisted living was inappropriate. A nursing facility must make care decisions in good faith based upon honest and competent assessment of the patient's condition, capacities and needs. The jury apparently believed the nursing facility was wrong to place financial considerations above the patient's needs by moving her out to move in another who would not have reimbursement issues. **Easler v. Valley Falls Terrace, 2010 WL 5574671 (Ct. Comm. Pl. Spartanburg Co., South Carolina, August 27, 2010).**

Patient's Fall: Circumstantial Evidence Points To Nursing Negligence, Court Lets Lawsuit Go Forward.

The patient's chart did not contain any explicit documentation of her falling in her hospital room.

The nurses who cared for her testified in court they had no specific recollection of caring for her and could only say in very general terms what their nursing progress notes meant.

The patient herself did not remember falling, nor was her husband able to testify that he witnessed her fall.

Nevertheless, the Court of Appeals of Ohio saw grounds to accuse the patient's nurses of negligence, based on circumstantial evidence that the Court was able to piece together from the chart.

Circumstantial Evidence

The patient showed good strength in both arms albeit with some weakness when the nurse assessed her at 8:30 p.m. that night. That had not changed since the time of the nursing assessment done when she was admitted two days earlier. Her routine admission chest x-ray showed no sign of a shoulder fracture.

At 2:30 a.m. the nurse obtained an order for restraints. The patient had been anxious and irritable when assessed at 8:30 p.m. the evening before.

At 3:30 a.m. the nurse noted that she restrained the patient, although the exact details were not in the chart. The nurse could only speculate later in court that it probably would have been a four-point soft handcuff restraint. Or maybe it was a vest restraint or maybe she just put up all four of the bedrails. She really did not know

At 4:30 a.m. the hysterical patient was agitated, restless and uncooperative, climbing out of bed and pulling on her IV. The nurse could only speculate that what happened was that the restraints were removed so that the patient could use the restroom.

At 4:13 p.m. the physician treating the patient's jaw got back the new x-ray of her shoulder and compared it with the old view of her shoulder in her admission chest x-ray. There was a new fracture in the shoulder. He testified in court it was unlikely she could have pulled at her IV as noted by the nurse in the early a.m. hours if her shoulder was already broken at that time.

One of the night nurses testified a nurse sometimes obtains an order for restraints but then uses his or her judgment whether or not to restrain the patient, based on the patient's current assessment.

However, according to the Court, there was no documentation of any relevant assessment data in the early a.m. or of any such exercise of nursing judgment.

There was no nursing documentation how and why the patient needed to be restrained, was restrained, then was not restrained, was able to try to get out of bed and then later that same afternoon had a new injury entirely consistent with trauma from a fall. The patient had the right to go forward with a lawsuit against the hospital. **Slenker v. St. Elizabeth Health Ctr., 2010 WL 5541692 (Ohio App., December 21, 2010).**

The patient was admitted with a fractured jaw from a fall at home. Soon after admission she began to experience psychological and behavioral problems related to bipolar disorder.

At 2:30 a.m. a nurse obtained an order for restraints. The patient had been anxious and irritable.

At 3:30 a.m. a nurse restrained the patient.

At 4:30 a.m. the patient was agitated, restless, uncooperative and hysterical and was pulling on her IV and climbing out of bed.

Later that afternoon an x-ray taken because she complained of pain revealed she had a fractured shoulder.

The only explanation is that the patient fell during the early morning hours while unrestrained, due to a negligent error or omission by the nurse or nurses assigned to care for her.

COURT OF APPEALS OF OHIO
December 21, 2010

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Skilled Nursing: US Court Finds Non-Compliance With Medicare/Medicaid Patient-Care Standards, Upholds Civil Monetary Penalty.

After investigating a complaint survey inspectors from the State of Maryland recommended that the US Centers for Medicare and Medicaid Services levy a civil monetary complaint against a skilled nursing facility for non-compliance with Medicare/Medicaid patient-care standards.

A penalty of $800 per day x 44 days, $35,200 in total was upheld by the US Court of Appeals for the Fifth Circuit.

The Patient

The resident in question was a seventy -two year-old woman diagnosed with organic brain syndrome, dysphagia and hypertension who had a history of a stroke. She was unable to communicate with others verbally and was completely dependent upon staff for performance of her activities of daily living.

Violation of Standards
Physician Consultation

The patient's weight dropped nearly ten percent, from 93 lbs to 84 lbs over less than two months. The facility's consulting dietitian noticed the weight loss and wrote a progress note that the patient was at risk for skin breakdown and, in fact, already had a pressure sore on her back and an advanced decubitus ulcer on her coccyx. She recommended a change in the care plan to include increase in dietary intake.

Three weeks went by after the dietitian's consult before anyone informed the resident's physician of the weight loss and the dietitian's recommendations.

The survey inspectors decided the delay in notifying the physician of the patient's weight loss and the need for dietary changes was a violation of Federal regulations, specifically, Title 42 of the Code of Federal Regulations, Section 483.10(b)(11), which requires a nursing facility to consult with a resident's physician immediately following a significant change in a resident's health status, that is, a deterioration in the resident's physical, mental or psychosocial condition.

The Court discounted the physician's testimony that he felt he was being kept informed. Survey inspectors are not bound by the doctor's personal opinion.

The skilled nursing facility violated two separate aspects of Federal patient-care standards.

A nursing facility is required to consult with a resident's physician immediately following a significant change in the resident's health status, that is, a deterioration in the resident's physical, mental or psychosocial status pointing to a need to alter the resident's treatment plan.

Ten-percent weight loss, from 93 lbs. to 84 lbs., is a significant decline in health status.

A nursing facility is required to assess a resident's skin integrity and provide necessary treatment and services to promote healing, prevent infection and prevent new lesions from developing.

A resident having a pressure lesion is not a violation per se.

The question is whether the resident's condition and needs were assessed, a plan of care developed and care provided to try to meet the resident's needs and, of course, whether documentation can be found in the chart that it was done.

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT
December 20, 2010

Violation of Standards
Pressure Sores

The patient was a high-risk for pressure sores and already had pressure sores on her coccyx and inner knee when she was readmitted to the facility after a hospital stay two months before the onset of her weight loss.

Over the ensuing six-month period the coccyx lesion worsened significantly and other pressure lesions developed.

Survey inspectors decided from a retrospective review of the chart that the patient's skin care violated Title 42 of the Code of Federal Regulations, Section 483.25, which requires a nursing facility to provide comprehensive assessment of the resident's needs and insure that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Specifically, the facility's nurses did not conduct daily inspections of the pressure sores on her coccyx and back as her care plan expressly required, allowed her to lie on a wet incontinence pad with a drying urine stain and a foul odor in violation of the care plan and the facility's own policies and did not ensure that her urinary catheter was functioning properly as required by the care plan and the facility's policies.

Civil Monetary Penalty Upheld

Federal regulations permit survey inspectors to recommend penalties ranging from $50 to $3000 per day when a nursing facility is not in compliance with Federal patient-care standards.

Factors to be considered are whether the violation caused actual harm or merely had the potential to cause harm but did not. Also considered is the facility's history of non-compliance. In this case the violations not only had the potential to cause significant harm but did in fact cause harm to the resident. The facility also reportedly had a history of six prior incidents of not notifying the physician of significant changes in health status. **Senior Rehab & Skilled Nursing Ctr. v. Health & Human Services, 2010 WL 5186658 (5th Cir., December 20, 2010).**

Patient's Fall: No Negligence Found.

The eighty year-old patient was in the hospital recovering after cardiac catheterization.

She requested privacy to use the bedside commode but then fell of the commode and fractured a rib and the orbital bone around her eye.

Her lawsuit alleged that hospital caregivers were negligent for failing to provide adequate supervision for a fall-risk patient.

The hospital argued that there was no assessment data pointing to concern over her falling off the commode and that it was reasonable to honor her request for personal privacy.

The jury in the State Court, Cobb County, Georgia sided with the hospital and awarded nothing. **Keeling v. Wellstar Cobb Hosp., Inc., 2010 WL 4971764 (St. Ct. Cobb Co., Georgia, August 12, 2010).**

Patient's Fall: No Negligence Found.

The sixty-eight year-old patient was in the rehab center recovering after a hip fracture from a fall at home when he fell again and fractured his hip in another place and tore the meniscus in his knee.

The patient's expert in physical rehabilitation testified in general terms that the proper way to transfer a patient such as this one is for the aide to put a gait belt on the patient waist, then stand behind him and support him while the patient rises from the bed and sits in his wheelchair.

The aide involved in the incident testified that he bent down to lock the wheels of the wheelchair and the patient stood up from the bed on his own and fell.

After the patient fell his caregivers gave him pain medication, immediately reported the incident to his physician and got the x-rays right away that the physician asked for. There was no delay in responding to the patient's needs or any attempt at hiding what had happened.

A three-member arbitration panel ruled in favor of the rehab facility. **Ernharth v. Sovereign Healthcare, 2010 WL 2510064 (Arbitration, Orlando, Florida, March 5, 2010).**

Medication Side Effects: Patient Was Negligent To Drive Home.

While the patient was waiting for her radiation oncologist in the cancer treatment center the nurse came in and gave the patient an oral dose of Ativan.

About an hour later the patient was informed the radiation oncologist could not come in and treat her and she would have to come back the next day.

On the way home the patient crashed her car into a tree and was badly injured.

The nurse told the patient she could not tell her one way or the other whether she could drive after taking the Ativan.

Without checking with the doctor as the nurse told her to do the patient decided to drive herself home.

The jury found the patient 70% comparatively negligent for the car crash.

DISTRICT COURT OF APPEAL
OF FLORIDA
November 3, 2010

The District Court of Appeal of Florida ruled it was not unreasonable for the jury to return a verdict in the patient's lawsuit against the cancer center finding the patient herself seventy-percent at fault for her injuries from the car crash.

The patient told the nurse she had been prescribed Ativan before as treatment for situational anxiety after the passing of her husband. The patient was well aware of its action and its side effects.

The nurse told the patient to check with the radiation oncologist to see if it was OK before driving home. The oncologist did not actually come in to see the patient that day, but the decision to drive home was nevertheless the patient's own choice for which she was held largely responsible. **Drew v. Tenet St. Mary's, Inc., __ So. 3d __, 2010 WL 4320406 (Fla. App., November 3, 2010).**

Unauthorized Practice: Board Of Nursing Suspends LPN's License.

A licensed practical nurse's license was suspended for six months following a complaint that she falsified a telephone order for medication, administered medication without a valid order and failed to document the need for medication administered to a patient.

The Massachusetts Board of Registration in Nursing conditioned restoration of her license after six months upon completion of various continuing education programs and a comprehensive mental health examination.

Medication Was Given Before An Order Was Obtained

Assigned by a staffing agency to work in a nursing home, the LPN phoned the nurse practitioner to discuss the recommendations she had just received from the hospice nurse concerning a certain patient's pain management regimen.

When the nurse practitioner told her she would not go along with the hospice nurse's suggestions, the LPN revealed she had already gone ahead and given a dose of methadone. In fact, she had also already transcribed an order into the chart from the nurse practitioner for the methadone.

There is no proof that racial discrimination had anything to do with the Board's decision.

SUPREME COURT OF
MASSACHUSETTS
January 21, 2011

The Supreme Court of Massachusetts saw solid evidence that the LPN committed the acts she was accused of and ruled that those acts raised genuine questions about her ability to practice safely and effectively as a nurse.

The Court found no evidence to validate the allegations of racial discrimination the LPN had raised in her response to the Board's disciplinary measures. **MacLean v. Bd. of Registration in Nursing, __ N.E. 2d __, 2011 WL 172761 (Mass., January 21, 2011).**

Prison Nursing: Court Sees Deliberate Indifference To Inmate's Serious Medical Needs.

An inmate serving a thirty-five year prison sentence had a history of an old gunshot wound in his stomach.

An individual with a history of an abdominal gunshot wound is at increased risk for later developing a bowel obstruction.

The prison medical chart contained documentation alerting his caregivers and the physician and nurse practitioner responsible for the patient's care were aware of his history and risk of bowel obstruction, according to the US District Court for the Western District of Kentucky.

Signs of Bowel Obstruction Ignored Patient Treated as a Malingerer

The problem began with vomiting and sharp abdominal pain. A nursing assessment in the prison clinic found that his abdomen was firm and bowel tones were hypoactive. He was not moved into the prison infirmary until the guards became concerned that the other prisoners were getting restless over the issue that nothing was being done for him.

In the prison infirmary the findings included abdominal pain, decreased bowel sounds, vomiting, fever, high blood pressure, increased respirations, constipation, inability to eat or drink and elevated blood glucose and ketones.

The patient was at first sent to a segregation cell as punishment for malingering but soon was sent back to a medical observation cell. The physicians and nurses kept him under observation while his signs and symptoms worsened.

Not until he vomited emesis with a fecal odor did a physician finally have him transported to a hospital. Emergency surgery at the hospital revealed extensive infection, necrosis and gangrene in his small intestines. The patient was basically terminal by this point and soon died.

Civil Rights Lawsuit Upheld

The Court ruled there were grounds for the family's lawsuit against the prison medical personnel for violation of the deceased inmate's Federal Constitutional rights as well as state common law medical malpractice. **Williams v. Simpson, 2010 WL 5186722 (W.D. Ky., December 15, 2010).**

Nurses and other medical personnel treating inmates locked up in jails and prisons can be sued for violation of their patients' Constitutional rights as well as common law malpractice.

The Eighth Amendment to the US Constitution outlaws cruel and unusual punishment. Originally the Eighth Amendment was meant to outlaw extreme forms of torture, but the US Supreme Court has said that evolving standards mean that deliberate indifference to an inmate's serious medical needs is now considered a form of unnecessary and wanton infliction of pain.

The medical personnel in this case knew from the patient's history that his signs and symptoms were consistent with the possibility of a bowel obstruction, a condition which presented a serious risk to the patient's health and safety if not promptly diagnosed and competently treated.

Even the non-medical prison staff and other prisoners were aware something was seriously wrong with this man and that something serious needed to be done.

UNITED STATES DISTRICT COURT
KENTUCKY
December 15, 2010

Prison Nursing: Court Sees No Deliberate Indifference.

A prison inmate was seen by the prison's nurse practitioner for complaints of migraine headaches.

The nurse practitioner prescribed Inderal which was then administered by a prison staff nurse.

The patient was promptly seen by a physician in the prison clinic four days after seeing the nurse practitioner, for what the physician determined was an adverse reaction to the Inderal.

The physician discontinued the Inderal. He decided it was inappropriate in the first place due to the patient's pre-existing history of asthma and diabetes.

It is undisputed that the patient received prompt and appropriate treatment for his adverse reaction to the Inderal.

UNITED STATES DISTRICT COURT
KANSAS
January 19, 2011

The US District Court for the District of Kansas ruled that the nurse practitioner and the prison staff nurse did not violate the prisoner's Constitutional rights. There was no deliberate indifference to his serious medical needs.

The Court conceded that the nurse practitioner could conceivably be liable to the patient for malpractice for prescribing a medication which can cause complications for patients with his medical history and for prescribing the medication without first consulting with a physician.

However, the nurse practitioner and the prison staff nurse were at all times making a good faith effort to deal with their patient's problems and promptly responded when it appeared that their treatment was not effective. It could hardly be said they were subjecting him to form of cruel and unusual punishment by intentionally causing him to suffer needlessly. **Atkins v. Rhonda, 2011 WL 167033 (D. Kan., January 19, 2011).**

Stroke: Jury Clears Nurse From Allegations Of Negligence.

Testing done at the hospital for complaints of headaches revealed that the thirty-four year-old patient had a small aneurysm in her brain.

To try to repair the aneurysm the physicians performed a stent procedure involving introduction of a wire through an arterial opening in the groin.

After the stent procedure it eventually came to light that an artery in the brain was pierced by the wire itself. The patient suffered severe complications and is now paralyzed on her left side.

When the patient complained of weakness on her left side the patient's nurse promptly reported to the resident physician on duty.

The resident believed the patient's symptoms were related to a blood clot and told the nurse to continue the Heparin.

CIRCUIT COURT
ALACHUA COUNTY, FLORIDA
December 20, 2010

The jury in the Circuit Court, Alachua County, Florida awarded the patient $23,442,602 from the hospital for the physicians' negligence but nothing from the nurse's employer, a nurse staffing agency.

The nurse was not negligent. She did all that was expected of her by reporting a significant development in the patient's condition to the resident on duty.

Standards of nursing practice did not make it her responsibility to go over the resident's head to the neurosurgery service for a diagnosis of a stroke related to bleeding rather than clotting, a diagnosis which would have indicated, among other things, immediately stopping the Heparin. The hospital had no such policy for nurses caring for post-neurosurgery patients. **Gervato v. Univ. of Florida, 2010 WL 5596591 (Cir. Ct. Alachua Co, Florida, December 20, 2010).**

Low Hemoglobin: Nurses Faulted For Failing To Notify Physician Before Discharge.

The patient had an emergency appendectomy.

Still in the hospital a few says after surgery the patient was having abdominal discomfort, was running a fever and had blood in her stool. The surgeon ordered an abdominal CT scan and gave orders for the nurses to report to him if the patient's hemoglobin level dropped below 10.

The patient was discharged, but was back in the hospital, a different hospital, the same afternoon the day she was discharged. At that hospital her hemoglobin was found to be 9.6.

The second hospital went ahead with a colonoscopy and a laparoscopy. The surgeons found and corrected the damage from the appendectomy, that is, portions of the cecum and ileocolic vessels incorporated into the fascial closure of the incision, causing necrosis of intestinal tissue.

The chart from the first hospital revealed that the surgeon's order to be notified if the hemoglobin dropped below 10 had been transcribed by the nurses. The 8.9 hemoglobin level was in there as well.

The surgeon testified he would not have discharged the patient if the nurses had informed him that the patient's hemoglobin was only 8.9 the day he discharged her, as he had asked them.

COURT OF APPEALS OF ARIZONA
December 16, 2010

The Court of Appeals of Arizona ruled the patient had grounds for a lawsuit against the first hospital for the nurses' negligence in not seeing that the indicated lab value was brought to the surgeon's attention. The lawsuit also implicated the surgeon for his own carelessness. **Borowsky v. Scottsdale Healthcare Corp., 2010 WL 5238574 (Ariz. App., December 16, 2010).**

Emergency Room: Patient Dies From Pneumonia In The Hospital.

The sixty-two year-old patient was diagnosed with pneumonia shortly after she arrived in the hospital's emergency department.

The hospital did not have an open bed available at the time so the patient was kept in the E.R. holding area for almost twenty-four hours waiting to be admitted to a med/surg floor.

By the time she got to the floor she was anxious, diaphoretic, tachycardic and was hyperventilating. Soon she lost consciousness, became cyanotic and died.

The E.R. nurse noticed that the patient's O_2 sat had dropped to 80% even though she was on 5 liters of oxygen.

The E.R. nurse reported to the E.R. physician but did not follow up for new orders or other changes in what was being done.

CIRCUIT COURT
WAYNE COUNTY, MICHIGAN
May 1, 2010

The hospital settled the family's lawsuit filed in the Circuit Court, Wayne County, Michigan for $575,000 without admitting liability. The patient's and hospital's names are being kept confidential according to the terms of the settlement.

The patient reportedly showed clear signs of acute respiratory distress in the E.R., including anxiousness, hyperventilation and an ominously low level of oxygen saturation.

The E.R. nurse was apparently aware of the situation, but after the nurse reported the patient's status to the physician nothing further was done by the nurse or the physician except to wait for a med/surg bed to open up so that they could transfer the patient out of the E.R. **Confidential v. Confidential, 2010 WL 5574556 (Cir. Ct. Wayne Co., Michigan, May 1, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Infant Immunizations: New Consolidated Vaccine Information Statement Available.

On December 30, 2010 the US Centers for Disease Control and Prevention (CDC) published a new consolidated vaccine information statement to be used for routine infant immunizations for DTaP, *H. influenzae* type b, inactivated polio vaccine, pneumococcal conjugate vaccine, hepatitis B and rotavirus.

The new vaccine information statement contains the CDC's current recommended schedule for infant immunizations and information about patient-teaching for potential side effects.

A CDC-approved vaccine information statement must be provided to the patient or the patient's parent or adult guardian when any of a long list of vaccines are administered.

For more information and a copy of any of the current vaccine information statements visit the CDC's website at http://www.cdc.gov/vaccines/pubs/vis.

FEDERAL REGISTER December 30, 2010
Pages 82402-82405

Whistleblower: Nursing Supervisor Is Vindicated By Verdict.

A hospital surgical nursing supervisor with a spotless fourteen-year record was fired ten days after she voiced a complaint that the hospital's administrator had falsified records that he had personally certified a number of the hospital's nurses' annual CPR retraining, which neither he nor anyone else had actually done.

It came to light in the former nursing supervisor's lawsuit that the administrator had been fired from a previous job for falsifying time records and from another for poor performance.

The jury in the Circuit Court, Pinellas County, Florida awarded the former nursing supervisor $425,000 from the hospital as compensation for emotional distress and for the fact a new job she was able to obtain in a physician's office paid less, had fewer benefits and was less personally satisfying that her former position.

The jury ruled that complaining about illegal actions by a superior is expressly protected by the state's whistleblower-protection law. The hospital had no right to fire her. **Martell v. Tarpon Springs Hosp., 2010 WL 5485106 (Cir. Ct. Pinellas Co., Florida, September 29, 2010).**

Professional Nursing: Court Finds No Nurse/ Patient Relationship, No Liability For Malpractice.

An individual who happened to be an RN was hired as a technician by a company which manufactures and distributes surgically-implanted spinal stimulators used by neurosurgeons in the treatment of chronic back pain.

She was given assignments which included meeting one particular patient several times in doctors' offices to program the device, over a period of at more than six months.

Starting the day after the device was surgically implanted there were concerns over oozing, non-healing and later a purulent discharge from the surgical site which indicated that an ongoing infection was in progress.

She repeatedly counseled the patient that he needed to get back in to see the neurosurgeon, a problem for him because he had not yet paid the bill.

Although she is licensed as a registered nurse, the programming technician did not take it upon herself to provide professional nursing services in managing an apparent infection at the surgical site.

She was not required to confront the patient's neurosurgeon or to report the situation to the medical director of her company, contrary to what was claimed in the patient's lawsuit.

COURT OF APPEAL OF FLORIDA
January 14, 2011

The patient kept going to appointments with his pain-management physician and with his primary care physician, but neither of them had a firm grasp on the problem with the infection.

The technician checked back with the patient and with the neurosurgeon's office clerk to see if he had been in.

Eventually the patient became paralyzed from a spinal infection at the surgical site. The Court of Appeal of Florida ruled the patient had no right to sue the RN/programming technician or her corporate employer.

Although she was licensed as a registered nurse she never undertook the role of professional nurse managing the patient's wound-care issues and had no legal duty as his nurse to treat or advocate for him. **White v. ANS Systems, Inc., __ So. 3d __, 2011 WL 116146 (Fla. App., January 14, 2011).**