LEGAL EAGLE EYE NEWSLETTER

February 2012 For the Nursing Profession Volume 20 Number 2

Overdose: Nurse Manager's Misstatement Of The Facts Can Extend Statute Of Limitations.

The patient was discharged from the hospital on October 1, 2007.

Before he left, the patient and his wife met with the hospital's patient advocate to complain that he was given too much, that is, two doses only four hours apart of the OxyContin 20 mg ordered by his surgeon for pain following orthopedic surgery, then became lethargic, experienced complications including problems with his breathing and fell twice in his bathroom.

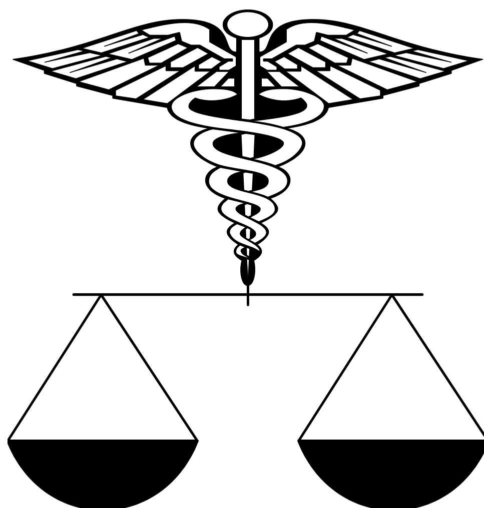
On October 9, 2007 the orthopedic unit nurse manager sent the patient a letter stating his chart showed that he was given his medications as ordered but apparently had a sensitivity which was promptly reported to the physician by his nurse and new orders obtained.

On October 27, 2007 the patient received the complete hospital chart, including his pharmacy records.

On October 6, 2009 the patient sued the hospital for malpractice allegedly committed at the hospital.

The hospital petitioned the court to dismiss the lawsuit on the grounds it was filed more than two years after the alleged malpractice, two years being the Iowa statute of limitations for healthcare malpractice.

The Court of Appeals of Iowa ruled there were legal grounds to extend the statute of limitations.



When a caregiver gives a patient an explanation that is not true the court can extend the statute of limitations so that the patient gets the full legal time period to file suit starting when he learned that what he was told was not true.

The hospital will not profit because the patient accepted, even briefly, that the nurse manager was telling the truth.

COURT OF APPEALS OF IOWA
December 21, 2011

Nurse Manager's Misstatement Extended the Statute of Limitations

The complete records the patient was given October 27, 2007 showed that the surgeon's original order was for 10 mg of OxyContin orally every 8 hours for pain, which the surgeon upped to 20 mg 3x per day because the patient was still in pain, and that that day the patient got 20 mg of OxyContin at 9:40 a.m. and 20 mg at 2:00 p.m.

The nursing progress note for 3:15 p.m. that day documented that because of the wife's concern over the patient's lethargy the surgeon was phoned and lowered the OxyContin to 10 mg.

That evening the patient's O_2 sat dropped to 55% which was corrected by having him take deep breaths. That night he fell twice in his bathroom.

The patient received two doses of his medication more quickly than ordered and that could explain what happened afterward, in contrast to what the nurse manager's letter said about a supposed sensitivity to OxyContin.

The statute of limitations for this case is two years, not from the date of the last treatment, but from the date the patient got the complete records which pointed the finger at a medication error, the Court ruled. **Hanssen v. Genesis Health, 2011 WL 6658318 (Iowa App., December 21, 2011).**

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Medication Error: Court Sees Basis For Liability, Punitive Damages.

While in the hospital the patient was mistakenly injected by a nurse with insulin that was not prescribed for him.

When the nurse realized the error she phoned the attending physician who told the nurse to check the blood glucose level every two hours and to phone her at home if it dropped below 120.

The physician called the hospital that night and learned that the blood glucose was 132 at 8:15 p.m. and 107 at 10:15 p.m. and ordered the blood glucoses discontinued until the next morning.

At 6:15 a.m. the blood glucose was 15. The patient soon died.

Nurse's Medication Error

The patient's daughter reportedly warned the nurse that the patient was not diabetic and did not use insulin but the nurse reportedly went ahead with the injection without making any effort to double-check the patient's identity or to verify that the medication was ordered for him.

If the daughter's statements were true the nurse's conduct could "transcend mere carelessness" as the New York Supreme Court, Appellate Division phrased it and "demonstrate reckless indifference to the deceased's medical needs" so as to justify punitive damages from the nurse.

Nurse's Previous Medication Error

It came to light during the preliminary discovery phase of the lawsuit that the same nurse had put ear drops in a patient's eyes two months before this incident, another blatant medication error that was revealed when the family's attorneys obtained a copy of the report prepared by the Federal investigators who responded to the incident in question.

The Court was particularly concerned with the lack of any systematic methodology at the hospital to identify and correct a risk of further errors by a staff member who had committed a blatant and egregious error in the past.

Documentation Was Back-Dated

The Court was also very concerned about the fact that the erroneous injection was not documented in the deceased patient's chart as a medication error until four months after the fact. There was no satisfactory explanation offered by the hospital to account for the delay.

After this incident Federal inspectors found that the hospital had no methodology in place to identify patterns of repeated medication errors by specific staff members, had not discussed trends for medication errors at quarterly quality assurance meetings and thereby failed to insure that its patients were free of significant medication errors as required by state and Federal regulations.

A medical facility's failure to provide appropriate safety precautions and staff training may constitute a basis for awarding a patient punitive damages if it is shown to amount to conscious disregard for patient safety.

Punitive damages are added to ordinary compensatory damages and in many cases far exceed the amount of the compensatory damages awarded.

NEW YORK SUPREME COURT
APPELLATE DIVISION
January 12, 2012

Willful failure to disclose pertinent medical information which a patient or patient's representative has the right to receive can be grounds for punitive damages, the Court went on to say.

The Court also found it problematic that the physician did not come to the hospital to see the patient and the Court felt the physician erred by ordering the glucose testing discontinued during the night until the next morning. **Marsh v. Arnot Ogden Med. Ctr., __ N.Y.S. 2d __, 2012 WL 87957 (N.Y. App., January 12, 2012).**

IV: No Nursing Negligence Found.

A registered nurse inserted a butterfly needle in a vein in the patient's right arm just above the elbow to give IV adenosine for an outpatient myocardial perfusion study.

The patient sued the clinic for negligence by the nurse which allegedly caused a median nerve injury in the arm which has been causing her constant pain in the arm, shoulder and fingers.

The patient's experts, a nurse and a neurologist, were unable to show how the nurse's technique used to insert the IV needle departed from the standard of care.

NEW YORK SUPREME COURT
APPELLATE DIVISION
January 17, 2012

The New York Supreme Court, Appellate Division, dismissed the patient's lawsuit.

The nurse allegedly failed to explain to the patient what she was doing and failed to follow up when the patient complained of pain. Even if that amounted to less than optimal nursing practice the Court could not see how it could have caused any injury to the patient.

Bad Outcome Reported By Patient Does Not Prove Negligence

The Court ruled that the patient's experts, an RN and a neurologist, had come up with opinions which were conclusory and thus insufficient to support a malpractice lawsuit. That is, the experts stated essentially that the nurse must have done something wrong merely because the patient reported pain afterward.

From the nurse's careful documentation of the process she used to insert the short, small needle into a superficial vein there was no logical explanation how a median nerve injury could have occurred, as the hospital's experts pointed out from their review of the chart. **Barrett v. Hudson Valley Cardiovascular, __ N.Y.S. 2d __, 2012 WL 149642 (N.Y. App., January 17, 2012).**

First Amendment: Nurse's Rights Were Not Violated.

A registered nurse was reassigned within the surgery department after an incident in which she was struck on the pant leg of her surgical scrubs by a specimen of pericardium tissue tossed in her general direction by one of the surgeons working in the operating room.

Her reassignment was triggered when the hospital learned that she had filed an official notice of claim form with the local city government risk-management office indicating her intent to seek damages from the city-owned hospital and the surgeon.

The US Court of Appeals for the Tenth Circuit ruled the nurse's right to Freedom of Speech under the First Amendment was not violated by her reassignment.

Healthcare workers are protected from employer reprisals when they speak out publicly on subjects of public concern, but not when they express their own personal grievances over situations which are personal to their own individual working environments, this being a case of the latter rather than the former in the Court's view.

There was also no sexual innuendo in the incident with the surgeon to support allegations of sexual harassment, the Court said. **Morris v. City of Colorado Springs, __ F. 3d __, 2012 WL 130672 (10th Cir., January 18, 2012).**

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Whistleblower: Nurse's Retaliation Case Allowed To Go Forward.

The Whistleblower Protection Statute provides legal protection to an employee who refuses to participate in or remain silent about illegal activity and is then terminated from employment solely for the employee's refusal to participate in or remain silent about the illegal activity.

The employee must be able to identify the specific law, regulation or statute that makes the activity in question illegal or be able to point to a specific public policy that has been articulated by the courts' common-law decisions.

The nurse alleged in general terms that racial discrimination was a factor in assigning priority and determining waiting times for patients, but she has to identify in her lawsuit the specific statute or regulation that makes that illegal.

COURT OF APPEALS OF TENNESSEE
January 17, 2012

An African-American registered nurse working as a triage nurse in the hospital's emergency department began to complain to her supervisors about a pattern of behavior she perceived by her Caucasian E.R. nurse co-workers of preferentially moving Caucasian patients ahead of African-American patients with comparable or more serious acuity levels to be seen more quickly by the physician.

The situation reached the boiling point when the nurse's own sister came to the E.R. Later that night the nurse could not find her sister as she had apparently left without treatment. While voicing her deep concerns to the supervisors on duty the nurse was forcibly removed by hospital security. When she got home she called a state agency complaint hotline number.

Several days later she was suspended and then terminated for alleged accusatory and confrontational behavior and for use of derogatory and profane language toward other members of the hospital staff regarding her sister's treatment.

The nurse filed suit against the hospital claiming protection under the state's whistleblower statute, known in Tennessee as the Public Protection Act.

The Court of Appeals of Tennessee agreed with the lower court that her lawsuit did not contain the technical requirements for a lawsuit under the statute. The Court, however, effectively breathed new life into her case by ruling her case should not have been dismissed without giving her lawyers the chance to redraft the lawsuit as needed. **Quinn-Glover v. Regional Med. Ctr., 2012 WL 120209 (Tenn. App., January 17, 2012).**

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Abuse Reports, Age Discrimination: Court Dismisses LPN's Lawsuit.

An LPN charge nurse sued her former employer, a nursing facility, for age discrimination after she was fired for non-compliance with the facility's policy for reporting abuse and neglect of residents.

The US Court of Appeals for the Sixth Circuit dismissed her case.

Nursing Facility's Policy Mandated Reporting of Known or Suspected Abuse or Neglect

The nursing home's written policy required any employee who witnessed or suspected abuse or neglect of a resident or misappropriation of a resident's property to report it immediately to the employee's own supervisor.

Supervisors, in turn, were required to inform the nursing home administrator immediately so that the situation could be promptly investigated.

Failure to report known or suspected mistreatment of a resident was grounds for disciplinary action, up to and including termination.

An aide heard another aide use a "hateful" tone telling a resident she could not come back to her room and feed her until she collected all of the other breakfast trays. Later that morning she heard the same aide yelling at a resident who asked her for more ice water, telling him she had brought him some earlier that morning and might not bring him any more until tomorrow if he kept pestering her.

The aide waited a while, then told the LPN charge nurse what she heard. The LPN charge nurse, however, did not relay it to the administrator. She decided instead to monitor the situation and see whether or not the problem persisted.

The next day the aide told the facility's QI director, who told the administrator, who interviewed both of the aides, two other aides and the LPN charge nurse and fired the first aide for verbal abuse of a resident and the LPN charge nurse for violation of the facility's mandatory reporting policy. The aide who went to the QI director was written up but was not fired because she did report what she heard, albeit later than she should have.

After her termination the LPN charge nurse, fifty-five years of age at the time, sued for age discrimination.

Age discrimination occurs when a forty-plus year-old is subjected to discipline not visited upon younger persons or replaced by a significantly younger person, unless the employer is able to show a legitimate, non-discriminatory reason.

Failure to follow a facility's legitimate policy for reporting of known or suspected abuse is a justifiable reason for termination.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
December 21, 2011

No Age Discrimination Found

The Court conceded the LPN charge nurse had a *prima facie* case of age discrimination simply because she was fired at age fifty-five and her former position was filled by a much younger person. That did not nail down her discrimination case but it did force the facility to come forward with a legitimate, non-discriminatory reason for her termination.

The Court found a legitimate, non-discriminatory reason for her termination in the fact she violated the facility's legitimate reporting policy that left no discretion to her to decide if the incident squarely fit the definition of abuse or whether it should be reported to the administrator.

Her supervisory responsibility was to report known or suspected abuse or neglect to the administrator. Other employees who were aware of the situation but did not go to the administrator were not supervisors and did not have the same responsibilities.

Moreover, the Court ruled it was not relevant to the charge nurse's duty to report known or suspected abuse that the first aide's actions were eventually determined not to have fit the definition of abuse, but merely displayed a "bad attitude" toward persons under her care which nonetheless justified her termination. **Rutherford v. Britthaven, Inc., 2011 WL 6415109 (6th Cir., December 21, 2011).**

Abuse: Facility Can Require Internal Reporting, Court Says.

A supervisor in a group home was fired for failing to report physical and verbal abuse of a resident to the long-term care ombudsman as required by state law.

In fact, she had hired the individual and let him start work before a background check was completed as required by state law and let him continue working after the incidents of mistreatment occurred.

The facility's policy is legitimate to require internal reporting of known or suspected abuse before reporting to outside agencies.

It is not meant to prevent mandatory reporters from fulfilling their legal obligations or to cover up incidents of abuse or neglect.

Management needs to take action immediately and cannot wait to hear from the ombudsman's office while abuse or neglect could be ongoing.

CALIFORNIA COURT OF APPEAL
January 11, 2012

In passing, the California Court of Appeal pointed out that the group home had a legitimate need for a policy which required employees to report known or suspected abuse internally before going to outside agencies.

The group home's policy was not intended to prevent mandatory reporters from doing their legal duty or designed to cover up alleged mistreatment. The policy was intended only to provide the means to correct the problem as quickly as possible.

Among other things, the abuse in question included a photograph being taken of a resident without written consent from the resident's guardian. **Swindle v. Res-Care, 2012 WL 86406 (Cal. App., January 11, 2012).**

Harassment: Did The Offensive Conduct Stop?

Several female hospital nurses filed suit for alleged sexual harassment by a male charge nurse.

The US District Court for the Western District of Texas magistrate's recommendation to the District Judge was to allow some of the cases and disallow others to go forward.

Federal and state anti-discrimination laws, among other things, require an employer to take prompt and effective action to stop sexual harassment once the employer learns or reasonably should have learned that it has taken place.

UNITED STATES DISTRICT COURT
TEXAS
January 3, 2012

In addition to having appropriate anti-harassment policies in effect before the fact, employers are required to take prompt and effective action after the fact once sexual harassment is reported by an employee to a supervisor or otherwise becomes known to supervisory personnel.

Action after the fact can include interviewing witnesses under assurances of confidentiality and non-retaliation to get all the facts, counseling, reprimanding, disciplining or firing the offender or separating the offender and the victim by transferring one or both of them within the institution.

In one nurse's case the harassment stopped when the offender was told to stop. That put an end to her right to sue.

In another nurse's case, the offender was only written up for "inappropriate interaction" rather than expressly reprimanded for violation of the hospital's anti-harassment policy and the harassment continued for two more months while no follow-up was done by management to assess whether the write-up had been effective. Her case, the magistrate concluded, was valid and could proceed to trial. **Taylor v. Seton Healthcare, 2012 WL 13680 (W.D. Tex., January 3, 2012).**

Americans With Disabilities Act: Court Applies New Definition Of Disability To Nurse's Case.

Amendments to the Americans With Disabilities Act which went into effect on January 1, 2009 broadened the definition of disability, that is, made the law more employee-friendly.

A disability is a physical or mental impairment, that is, any physiological disorder or condition affecting one or more body systems, such as neurological, musculoskeletal, special sense organs, respiratory, cardiovascular, reproductive, digestive, genitourinary, immune, circulatory, hemic, lymphatic, skin and endocrine which substantially limits a major life activity like caring for oneself, doing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating and working.

The US Congress reworded the definition of disability to eliminate the hurdle interposed by the US Federal courts that to be a disability an impairment must substantially limit a major life activity that is of central importance to most people's daily lives.

UNITED STATES DISTRICT COURT
KENTUCKY
January 5, 2012

A hospital medical/surgical RN was diagnosed with atrial fibrillation and began taking meds.

A month later she had a stroke, diagnosed as a thromboembolic event from a cardiovascular source. After speech therapy to resolve residual expressive aphasia she was cleared by her cardiologist and a neurologist to return to work, except that she was restricted to a 5 day x 8 hour work week with no additional on-call shifts, due to lingering problems with fatigue.

Other staff nurses and managers accommodated her for a while by picking up more than their share of extra shifts required by absences and heavy patient censuses, but eventually the nurse was fired.

The US District Court for the Western District of Kentucky dismissed the nurse's disability discrimination lawsuit.

Definition of Disability

The Court said that fatigue which prevents a person from working more than forty hours per week would not have been considered a disability before but now would be a disability under the more employee-friendly January 1, 2009 amendments to the Americans With Disabilities Act. However, being disabled is only one element of a disability discrimination case.

Nurse Was Not a Qualified Individual With a Disability

The requirement still remains intact that to benefit from the anti-discrimination laws a disabled individual must be a qualified individual with a disability, one who, with or without reasonable accommodation can fulfill the essential functions of the job.

The law still gives considerable deference to the employer's judgment in defining essential job functions. Working extra on-call shifts was required of med/surg nurses by hospital personnel policies.

The employer making non-disabled personnel assume more than their pro-rata share of the burden of filling on-call vacancies to accommodate a disabled co-worker is an accommodation that is not reasonable and it is not something a disabled employee has a legal right to expect, the Court said. **Azzam v. Baptist Healthcare, 2012 WL 28117 (W.D. Ky., January 5, 2012).**

Healthcare Fraud: Doctor Convicted Based On Nurses' Testimony.

The physician was a board-certified internist who owned and operated a solo hematology/oncology practice.

Much of the activity in the office involved outpatient administration of chemo and other drugs by nurses employed by the physician. The fraud charges against the physician stemmed from overbilling for the dosages of the drugs actually administered and billing for office visits where the physician supposedly saw the patients when in fact only a nurse interacted with them.

The physician was convicted on twenty-eight separate counts and sentenced to five years in prison plus more than one million dollars restitution.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
January 18, 2012

The US Court of Appeals for the Fourth Circuit upheld the physician's convictions and the sentence imposed.

Nurses testified they accurately recorded the dosages of the drugs they administered to the patients, but the physician went back and changed their chart notes.

The nurses said they were told to split 40,000 unit vials of Procrit, giving 20,000 each to two different patients but recording each patient as having received 40,000 units for which the physician billed Medicare and other insurances.

The nurses also testified there was a standing practice in the office to bill office visits as Level 3, involving contact with the physician, when the patients only came in for an injection from the nurse and never saw the physician.

After Federal subpoenas came in the physician ordered an office-wide audit involving wholesale shredding of patient files, which was where the nurses finally refused to go along. **US v. Polin, 2012 WL 130753 (4th Cir., January 18, 2012).**

Bedsores: No Negligence Found.

The elderly patient was admitted to the hospital's intensive care unit after she was found at home lying in a pool of blood. She was being cared for at home by her daughter.

Her medical problems included anemia from loss of blood, bladder cancer, acute kidney failure, diabetes and hypertension. She had a history of a stroke which left her unable to talk and partially paralyzed. She did not have decubitus ulcers or bedsores when she was admitted to the hospital.

After discharge following surgery for bladder cancer the family discovered she had bedsores and took her back to the hospital where she died four days later from cardiopulmonary arrest.

The hospital provided expert testimony that bed sores may be unavoidable in patients in this patient's condition, even when entirely appropriate nursing care is provided.

UNITED STATES DISTRICT COURT
MISSISSIPPI
January 9, 2012

The US District Court for the Northern District of Mississippi dismissed the family's lawsuit against the hospital.

The case was dismissed even though the nursing admission assessment in the chart identified the patient as high-risk for problems with skin integrity, the care plan provided that she was to be turned every two hours and the nursing flow charts failed to document she was turned according to the care plan, if at all.

The Court accepted expert testimony submitted by the hospital that bedsores can be unavoidable in a patient like this one with complex medical issues and care needs, even with the best of nursing care.

At the same time there was no expert testimony submitted by the family that substandard nursing care, even if it was responsible for the patient's bedsores, had any cause-and-effect relationship with her death. **Jackson v. Oktibbetha County Hosp., 2012 WL 39399 (N.D. Miss., January 9, 2012).**

Skilled Nursing: Court Extends Patient's Medicare Eligibility.

The nursing facility resident was notified that Medicare would be terminating his eligibility because his short term and long term physical and occupational therapy goals had been achieved.

Nevertheless his family appealed the decision to the state quality improvement organization and eventually the US District Court for the Eastern District of New York ruled he was eligible for continued skilled nursing coverage through Medicare.

Federal regulations state that if the patient's overall condition would support a finding that recovery and safety can be assured only if the total care is planned, managed and evaluated by technical or professional personnel, it would be appropriate to infer that skilled services are being provided, 42 CFR 409.32(b).

UNITED STATES DISTRICT COURT
NEW YORK
December 9, 2011

During the five-day period in question the patient needed not only to receive personal care in the facility but was also placed back on restorative rehabilitation which included therapeutic exercise and training for transfers, gait, balance, elevation and endurance, the stated goals being that he would be able to ambulate on outdoor surfaces, become independent in car transfers, be able to negotiate up and down curbs and cross a street in the time frame of a stop light.

According to the Court, his stay in the facility while receiving these services would be considered skilled nursing care covered under Medicare Part A rather than just personal care not covered by Medicare. **Glick v. Johnson, 2011 WL 6140523 (E.D.N.Y., December 9, 2011).**

Cardiac Intensive Care Nursing: Court Rules Nurses Met The Nursing Standard Of Care.

The thirty-two year-old patient was admitted to the hospital for surgery to correct a congenital heart defect.

During the surgery the surgeon punctured the patient's healthy mitral valve, an error which the surgeon was not immediately able to correct. Multiple additional surgeries over the next two days were not successful at repairing the damaged mitral valve and it had to be replaced with an artificial valve.

During that two-day interval it was necessary for the patient to receive heparin which was administered by the physicians.

In between surgeries and for six days following the last surgery the patient was in the cardiovascular ICU where the hospital's nurses cared for him.

In the cardiovascular ICU serious complications arose, including cardiac distress, multi-system organ failure, life-threatening bleeding, a significant decline in his platelet count, weak pulses and signs of blood clotting in his extremities.

Due to the blood clotting, the left leg above the knee, all his fingers and the toes of his right leg had to be amputated.

Jury Rules for the Patient

The surgeon settled with the patient for an undisclosed sum of money. Then the patient's lawsuit went to trial against the hospital for the alleged negligence of the hospital's cardiovascular ICU nurses. The jury awarded more than seven million dollars from the hospital in addition to the settlement from the surgeon.

Appeals Court Voids Jury's Verdict

The Court of Appeals of Texas voided the jury's verdict and did not order a re-trial of the case against the hospital.

The Court ruled the jury's verdict was tainted when the judge allowed the patient's physician/expert to testify erroneously that the standard of care for the hospital's cardiovascular ICU nurses required them to recognize the signs and make the diagnosis of heparin-induced thrombocytopenia, communicate their diagnosis to the physicians and then advocate on the patient's behalf up the chain of command.

Instead, the Court accepted the expert testimony of the hospital's own cardiovascular ICU nurse manager.

The patient's physician expert's opinion about the standard of care for the cardiovascular ICU nurses conflicts with legal prohibitions against the practice of medicine by nurses.

The patient's expert testified the dropping platelet count meant the patient was experiencing heparin-induced thrombocytopenia.

The patient's expert construed a nursing journal article he found saying that nurses should assess the patient and recognize and report possible signs of heparin-induced thrombocytopenia to mean that the nurses should have sorted through the complicated and conflicting physiologic data, made the right medical diagnosis, realized the patient's physicians had misdiagnosed the patient and reported that to the physicians and then acted as patient advocates by initiating the nursing chain of command to get a physician to recognize and act upon the medical diagnosis the nurses had made.

The hospital was also liable for failing to train the nurses to realize that was what they were supposed to do, the patient's expert went on to say.

COURT OF APPEALS OF TEXAS
December 29, 2011

Nurse Manager's Testimony
Nursing Diagnosis / Interventions

Nursing diagnosis differs from medical diagnosis, the hospital's nurse manager testified. Medical diagnosis has to do with the medical condition of the patient and specific treatments a physician would perform or order, while nursing diagnosis has to do with what a nurse can do to intervene and support the patient's care.

Nursing diagnosis, according to the North American Nursing Diagnosis Association is a clinical judgment about individual, family or community responses to actual or potential health problems or life processes. A nursing diagnosis provides the basis for selection of nursing interventions to achieve outcomes for which the nurse is accountable.

The definition of nursing diagnosis is basically identical in the state Nurse Practice Act, except that, unlike NANDA standards, it has the force and effect of law.

While he was on heparin the nurses were required to monitor his signs, symptoms and responses, chart them and report to the physician. Only a physician can order or discontinue medication, but a nurse is nevertheless required to know why a medication is ordered and its effects, including adverse reactions such as the risk of bleeding association with administration of blood-thinning medication like heparin.

The totality of what was going on with the patient was consistent with mitral valve regurgitation, reaction to vasopressor medication as well as heparin-induced thrombocytopenia, the Court said.

According to the Court, the patient's physician/expert in effect called for the hospital's cardiovascular ICU nurses to engage in the unauthorized practice of medicine by singling out a medical diagnosis from competing theories as to what could have been going on with the patient and then take action accordingly.

It would be wrong to hold the nurses to a higher standard than that allowed by law, not to mention that it was also in no way conclusive, the Court believed, that heparin-induced thrombocytopenia was the correct medical diagnosis. **Methodist Hosp. v. German, __ S.W. 3d __, 2011 WL 6938521 (Tex. App., December 29, 2011).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Nursing Home Negligence: Arbitration Will Go Forward Despite AAA Policy Change.

The day after the resident was admitted to long-term care, his daughter, whom he had named in his durable power of attorney, signed several documents related to his admission, including an arbitration agreement.

Slightly more than three years later, after the resident had died, the same daughter, acting as executor of her late father's probate estate, filed a lawsuit against the nursing facility alleging that her father's death was caused by negligence committed at the facility.

The nursing home countered the daughter's civil lawsuit by asking the court to take the case off the jury trial docket so that it could be resolved by alternate dispute resolution, that is, by arbitration based on the arbitration agreement.

AAA Has Changed Its Position On Pre-Dispute Arbitration Agreements

One of the estate's arguments against arbitration was that the American Arbitration Association (AAA), a widely used provider of arbitration forms and arbitration services, recently changed its official position and will no longer handle arbitrations where the arbitration agreement, as in this case, was signed before the actual dispute arose between the patient or patient's representative and a healthcare provider.

The Court of Appeals of North Carolina ruled that did not change the fact there is still a strong public policy in favor of alternative resolution of disputes in the healthcare arena.

The basic AAA arbitration agreement signed in this case called for the arbitration to proceed by the AAA rules, and that was how it would proceed, the Court said, even if the AAA itself would not be involved.

No Problem With the Agreement

The arbitration agreement was separate from the rest of the admission papers, was clearly labeled as a arbitration agreement, was presented to the daughter for her voluntary signature, urged her to consult with her attorney before signing and was not held out as a condition of admitting or keeping her loved one in the facility.

The daughter had the opportunity to read the arbitration agreement, knew what it meant and signed it voluntarily. Like any other contract, the arbitration agreement was entitled to enforcement at the nursing facility's behest, the Court ruled. **Westmoreland v. High Point, __ S.E. 2d __ , 2012 WL 120043 (N.C. App., January 17, 2012).**

Incomplete Nursing Documentation: Jury Gives Critical Care Nurses The Benefit Of The Doubt.

The patient sued the hospital where she was treated for multiple trauma after a serious motor vehicle accident. She claimed in her lawsuit that her spinal injuries were compounded by mishandling at the hands of the nurses in the hospital's neurocritical unit.

There were orders from the physicians to the nurses for spine precautions which included use of a three-person log-rolling technique any time the patient was moved in bed for treatments, bathing, toileting, linen changes, etc.

The nursing progress notes did not explicitly document use of the above technique each time she was moved.

Hospital standing policies also called for posting a spine-precautions sign above the head of the bed of any spine-precaution patient, which apparently was not done this time.

"If you didn't chart it, you didn't do it," is an accepted maxim of nursing practice.

It means that the defendant nurses and hospital could have difficulty proving something not documented was actually done.

It does not necessarily prove affirmatively that care was not provided, as the patient's expert erroneously testified. It just sets up a risky question of credibility for the jury to resolve.

COURT OF APPEALS OF UTAH
December 22, 2011

The patient's physician expert testified that lack of explicit mention of the three-person log-rolling technique each time it was noted that the patient received care in bed over eleven days was affirmative proof the nurses did not use correct technique and, therefore, that changes seen on a later spinal MRI compared to one right after admission were caused by nursing negligence.

The Court of Appeals of Utah, however, affirmed the jury's verdict of no negligence by the nurses based on the testimony of the hospital's nursing expert that it was the practice in the neurocritical unit always to log-roll spinal patients unless the nurses were told otherwise and that it was fully documented in the chart the patient was on spine precautions. **Turner v. Univ. of Utah Hosp., __ P. 3d __, 2011 WL 6425438 (Utah App., December 22, 2011).**