LEGAL EAGLE EYE NEWSLETTER

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Fetal Demise: Court Sees No Nursing Negligence, Dismisses Parents' Lawsuit.

The patient had had an extensive obstetric workup at a university teaching hospital for this her fourth pregnancy.

Her diagnosis was invasive placentation. She was told it could cause life-threatening bleeding and would require a cesarean delivery and hysterectomy.

At twenty-one weeks into her pregnancy she phoned the university hospital to report abdominal pains and vomiting. She was told to come to the university hospital, more than an hour away, or go to a local hospital nearer her home.

She and her husband arrived at a nearby small public community hospital in the emergency department at 2:45 p.m.

The emergency department immediately directed her to the family birth center at the hospital.

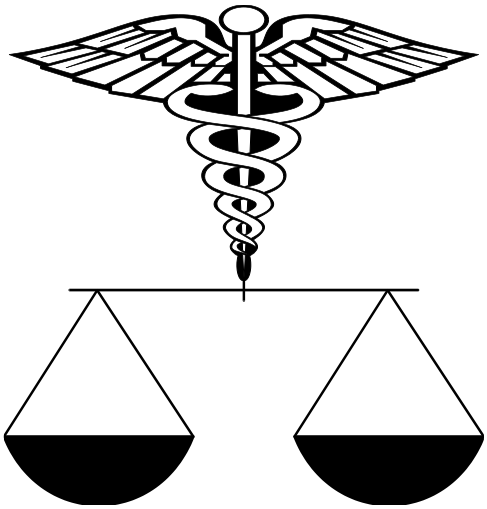
Hospital policy was that all women pregnant at more than twenty weeks receive their triage on that unit.

In the initial triage the patient reported to her nurse that she was not in labor, was not in pain and was not bleeding.

The nurse classified her as urgent, a mid-level triage acuity classification at this hospital.

By 3:10 p.m. the triage nurse had gone to the Doppler after the fetal monitor she had started was showing no fetal heartbeat.

The triage nurse got another nurse to check with the Doppler. That nurse also could not get a fetal heartbeat.



This patient was not in labor, was not bleeding, had stable vital signs and her membranes had not ruptured.

The standard of care allows a patient like this to be triaged by an RN and the RN to communicate the RN's findings and get orders from a physician by phone, for a patient who has arrived unexpectedly on an obstetric unit.

COURT OF APPEALS OF WASHINGTON
June 22, 2019

At that point the patient and her husband demanded an ultrasound. Since the patient had no ob/gyn at the hospital the nurse phoned the on-call physician whose name came up next on the hospital computer, a family practitioner who practices at the hospital.

The physician was seeing patients at the clinic and could not come to the hospital at that moment.

He gave the triage nurse a verbal order for an ultrasound. He planned to come to the hospital later to see the patient and discuss a possible transfer to the university facility.

The ultrasound tech reported no viable heartbeat at 4:12 p.m. The nurse phoned the physician again. At 5:00 p.m. a radiologist confirmed that the ultrasound indicated fetal demise.

No Nursing Negligence

The Court of Appeals of Washington found no nursing negligence in the triage nurse's handling of the case.

The parents' lawsuit did not allege the nurse, the physician or the hospital were responsible for the loss of the pregnancy. However, the lawsuit did seek damages for aggravation of the patient's preexisting PTSD over the way her case was handled by the triage nurse and the hospital itself.

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Fetal Demise: No Nursing Negligence.

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The nurse's initial triage indicated the patient was not in immediate need of in-person attention from an obstetrician.

According to the Court, the triage nurse's initial classification of the patient was correct. The patient's condition was urgent, but not critical or emergent.

Therefore it was within the standard of care for the nurse to communicate with an available physician by phone, share her assessment data and receive orders by phone pending the physician's coming to the hospital later that evening in person to assess the patient and formulate a plan for her medical care.

The Court refused to find fault with a small public community hospital for having a family practice physician on the on-call list who could be contacted for an urgent obstetric patient who did not appear during nursing triage to require immediate attention from an obstetrician qualified to handle a complex obstetric emergency.

The nurse was not to blame for contacting a family practitioner rather than advocating for a specialist, based on her assessment of the patient. **Curley v. Hospital, 2019 WL 3287074 (Wash. App., June 22, 2019).**

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Patient's Falls: No Modification Of The Care Plan, Negligence Case Will Go Forward.

As a general rule the nursing standard of care for fall risk assessment and fall prevention care planning must be proven by expert testimony if the question comes up in a court case.

However, in this case a jury of lay persons will need no expert testimony to see that it was negligent for the patient's nurses to fail to update his fall care plan for almost a year while he continued to fall numerous times.

The only change was the addition of a seatbelt alarm on the patient's wheelchair, which did nothing to stop him from falling.

The patient routinely ignored the seatbelt alarm, got up out of his chair and repeatedly fell until his last fall proved fatal.

UNITED STATES DISTRICT COURT
MASSACHUSETTS
July 8, 2019

A seventy-nine year-old dementia patient died six days after a fall in a nursing facility.

The family filed a wrongful death lawsuit alleging that the fall was caused by the negligence of the facility's nurses.

The facility tried to defend the lawsuit by petitioning for a summary judgment of dismissal on the grounds the family had no expert testimony to back up the case.

The United States District Court for the District of Massachusetts dismissed some of the allegations but let one critical aspect of the family's case go forward.

The allegations as to the inadequacy of the initial fall risk assessment on admission and initial care planning for fall mitigation required expert testimony. Without expert testimony those allegations had to be dismissed as unfounded.

However, there were repeated non-injury falls for almost a year after his admission with no modification of his care plan other than the addition of an ineffectual seatbelt alarm on his wheelchair.

Then he fell and sustained a closed head injury, was hospitalized later that day and died in the hospital six days later.

The Court ruled no expert testimony was needed to prove negligence from the fact no professional modification and correction was done with a dementia patient's fall care plan for almost a year while he continued falling, leading up to the final event that proved fatal. **Katz v. Senior, 2019 WL 2914012 (D. Mass., July 8, 2019).**