LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
April 2006 Volume 14 Number 4

Hospital Bed Strangulation, Positional Asphyxia: Case Raises Complex Legal Issues.

A nursing assistant discovered the nursing home resident at 2:00 a.m. in bed with his head trapped between the mattress and the side rail of his bed. His lower limbs were touching the floor next to the bed.

An LPN responded to the aide's call for help. She and a second aide were able to free the resident from his entrapment and reposition him on his bed, but he had died.

The director of nursing and the administrator were called to the facility. They made arrangements to contact the family and notified the coroner.

According to the Court of Appeals of Ohio, the director of nursing jotted down notes when she first spoke with the LPN, then crumpled up her notes and threw them in her desk drawer.

When first interviewed by the coroner the LPN stated the patient's airway was not blocked, then changed her story while talking to the coroner a week later.

(Continued on page 3)

Inside this month's issue ...

April 2006
New Subscriptions
See Page 3

Hospital Bed Strangulation, Positional Asphyxia: Case Raises Complex Legal Issues.

(Continued from page 1)

No Ruling Yet On Liability

No court has ruled whether the nursing facility is liable for the patient's death.

Quality Review / Peer Review Confidentiality

The Court of Appeals of Ohio has been wrestling with pre-trial evidentiary questions. It ruled the LPN must testify what she first told the administrator, even though it was written down for purposes of internal quality review.

A healthcare facility must keep a log of its internal quality review or peer review committee's deliberations. Without recording what was said, the facility must note who met, when, and what in general was discussed. Without revealing the contents of documents, the facility must catalog by general description the documents that were considered by the committee during its deliberations. A healthcare facility cannot later claim in court the right to invoke the privilege of confidentiality without having done its homework. **Smith v. Manor Care of Canton, Inc., 2006 WL 636975 (Ohio App., March 13, 2006).**

All information, data, reports and records made available to a quality assurance committee or utilization committee of a hospital or long-term care facility are confidential.

An incident report or risk management report is a report of an incident involving injury or potential injury to a patient as a result of patient care prepared by or for the use of a peer review committee of a health care facility and within the scope of the functions of that committee.

Proceedings and records of internal review committees cannot be obtained in pre-trial discovery or introduced into evidence at trial.

An individual cannot be compelled to testify what he or she told a quality review committee within the scope of its investigation.

COURT OF APPEALS OF OHIO
March 13, 2006