LEGAL EAGLE EYE NEWSLETTER

January 2003 *For the Nursing Profession* Volume 11 Number 1

Alzheimer's: Court Says Nurse Assaulted By Patient Cannot Sue Patient Or Family.

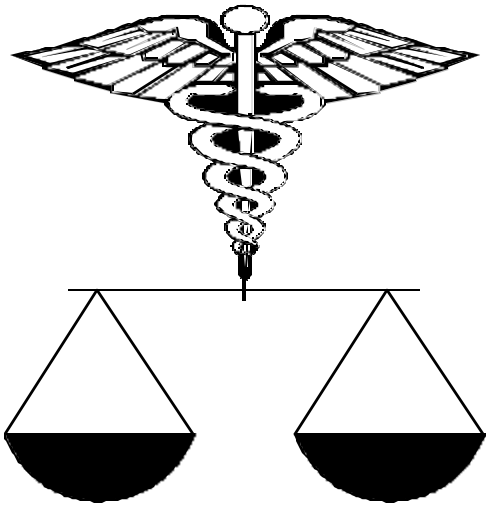
Because the patient was not mentally competent to care for himself and posed a danger to himself and others the patient's daughter was named as his legal guardian.

As legal guardian she had him admitted to the long-term care unit of the local county hospital. Two weeks after admission the staff had him transferred from the long-term care unit of the hospital to the hospital's psychiatric unit because of agitation and assaultive behavior toward staff.

His daughter insisted he be taken off the psych unit. After three weeks he was transferred back to the long-term care unit and placed in the Alzheimer's section. The interdisciplinary team believed his aggressive acting-out had subsided to the point where a less restrictive placement in long-term care was more appropriate for him than the psych unit.

In the Alzheimer's section he opened a fire door and set off the alarm. As the charge nurse tried to redirect him from leaving he pushed her down and injured her.

The charge nurse sued the daughter, the physician and the patient. The Superior Court of New Jersey, Appellate Division, ruled there were not sufficient grounds for the lawsuit



The patient's daughter insisted her father be moved back to the long term care unit from the psychiatric unit.

It was the care team who made the decision.

The daughter had no control of her father or of placement decisions affecting him and was not responsible for his actions toward his nurses.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
November 20, 2002

Family Member Ruled Not Liable

The court ruled a patient's family member is not legally liable to caregivers for trying to have input in a placement decision regarding the patient.

The daughter had no choice but to place him in the facility. Then it became the facility's ultimate responsibility for care and placement decisions.

Physician Ruled Not Liable

In this case the charge nurse, the physician and the multidisciplinary team were all employees of the facility.

As a general rule, state worker's compensation laws establish worker's compensation as the only legal recourse for employees' on-the-job injuries. Negligence lawsuits are not allowed against the employer and co-employees, whether or not actual negligence can be proven.

Patient Ruled Not Liable

The trial judge instructed the jury they had to evaluate the patient's mental capacity to decide if he could appreciate the nature and consequences of his actions, which the jury decided he could not.

The Appellate Division ruled that is the correct approach in cases involving caregivers assaulted by Alzheimer's patients.

(Continued on page 3)

Inside this month's issue ...

January 2003

Confidentiality: Court Ruling Re Incident Reports.

The son who was probate administrator of the deceased nursing home resident's estate sued the nursing home alleging lack of proper care and supervision and violations of the state's Nursing Home Residents' Bill of Rights.

The court had to decide whether to allow the son's attorneys access to any existing records of accidents or unusual occurrences involving the resident.

The peer review / quality assurance privilege is not absolutely ironclad.

Whether a document has been labeled an incident report or labeled that it was prepared in anticipation of litigation or labeled confidential is not the issue.

Can the plaintiff get the information elsewhere without undue hardship?

DISTRICT COURT OF APPEAL
OF FLORIDA
November 20, 2002

The District Court of Appeal of Florida ruled if a document was in fact prepared by management in anticipation of litigation it is absolutely privileged.

If a document contains the deliberations, conclusions or recommendations of an internal quality review committee it is privileged, unless the plaintiff cannot get the basic factual data anywhere else.

If the basic facts of the incident that gave rise to the lawsuit are documented in the patient's medical records, which the personal representative has the right to see, there is no need for the personal representative to get access to confidential incident reports, the court ruled. **1620 Health Partners, L.C. v. Fluitt, __ So.2d __, 2002 WL 31557951 (November 20, 2002).**

Confidentiality: Court Ruling Re Incident Reports.

The daughter who was probate administrator of the deceased hospital patient's estate sued the hospital over an incident where her mother apparently was allowed to fall and strike her head on the floor in the radiology department where she had been taken for a scan to rule out a pulmonary embolus.

The court had to decide whether to allow the daughter's attorneys access to the incident report. The trial court ruled the incident report was not privileged and ordered the hospital to turn it over to the daughter's attorneys.

The hospital appealed that decision.

In Camera Inspection Ordered

The Court of Appeals of Ohio ruled the trial judge was not necessarily wrong, but should have been more thorough. The judge should have compared the incident report with the patient's medical records.

Undue Hardship Is Exception To Peer Review / Quality Assurance Privilege

If the basic facts of the incident were documented in the medical records, there would be no need for the daughter's attorneys to see the incident report.

If the basic facts of the incident were not documented in the medical records, there would be grounds to order the hospital to turn over the incident report.

Basic Facts of the Incident Not Adequately Charted

The physician, nurse and imaging technician each charted that the patient had a head laceration and was vomiting.

However, no one charted how the head laceration happened to occur or whether the vomiting started before or after the head laceration appeared.

The Court of Appeals seemed to think it would amount to undue hardship for the daughter in making her case to have to rely on charting that was left incomplete deliberately. **Johnson v. University Hospitals of Cleveland, 2002 WL 31619030 (Ohio App., November 21, 2002).**

Catheterization: Nurse Followed The Standard Of Care.

Before starting surgery for amputation of a toe and for vascular reconstruction a young boy was to get a urinary catheter. The catheter was to be inserted by a registered nurse.

The nurse first tried to push a #16 French latex rubber Foley catheter through the urethra, which did not work.

Rather than push through the resistance the nurse tried again with a smaller-diameter #12, which still did not work.

Then the nurse deferred to the physician. He also could not get in through the urethra so he did a procedure above the pubic bone to go directly into the bladder.

The hospital provided affidavits from the nurse herself and from a physician showing the particular steps to be followed during a urinary catheterization and showing that the nurse followed those steps.

This evidence shows the nurse followed the legal standard of care. Her employer the hospital is entitled to have the case against it dismissed.

COURT OF APPEALS OF TEXAS
December 11, 2002

The Court of Appeals of Texas approved a summary judgment of dismissal in favor of the hospital, leaving the physician as the only defendant against whom the case would go to jury trial for compensation for the boy's bladder fistula.

The court said there was no question the hospital correctly stated the legal standard of care for a nurse in this situation and proved she followed that standard. **Spinks v. Brown, __ S.W.3d __, 2002 WL 31753580 (Tex. App., December 11, 2002).**

Alzheimer's: Aide Slaps Patient, Ruled Guilty Of Abuse.

The Appellate Court of Illinois recently upheld charges of abuse filed by her supervisor against an aide working with Alzheimer's patients in a nursing home.

That is, the court upheld the state department of public health's decision to delete her name from the registry of certified nurse's aides allowed to work in the state.

Patient Struck Caregiver First

The aide had been working in the nursing home at least eight years, was familiar with Alzheimer's patients in general and had been caring for this patient off and on for four months.

While trying to keep the patient from climbing out of bed, just after the aide and the LPN charge nurse had transferred the patient from a wheelchair to the bed, the patient kicked the aide.

The aide then slapped the patient and was immediately corrected by the nurse. The court did not discuss the aide's reasoning, justification, excuse or mitigating circumstances. Slapping a patient is abuse. **Ulysse v. Lumpkin, __ N.E. 2d __, 2002 WL 31506601 (Ill. App., November 12, 2002).**

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Alzheimer's: Court Says Nurse Assaulted By Patient Cannot Sue Patient Or Family (Continued.)

(Continued from page 1)

Caregivers Assaulted By Patients

As a general rule a caregiver can sue a patient for personal injury when a negligent or intentional act by the patient injures the caregiver.

In general our society holds everyone accountable in civil lawsuits for the consequences that reasonably prudent persons would expect as a result of their actions. Even if the actor does not subjectively intend, expect or even comprehend the possible consequences, the actor is nevertheless responsible for what anyone would objectively expect to happen.

Diminished Mental Capacity

Diminished mental capacity can be a defense to criminal charges. If a person has a temporary or permanent cognitive deficiency and cannot appreciate the nature and consequences of his or her actions, and can prove that, he or she is not liable under the criminal justice system.

In civil cases, however, where one private party is suing another for compensation for personal injury or property damage, diminished mental capacity is generally not recognized as a legal defense.

For example, in a legal precedent cited by the court, a diagnosed schizophrenic receiving regular injections of medication to control his behavior was held liable to his landlord for damaging his apartment, apparently because he failed to go in for his scheduled injections and became out of control.

Right or wrong, diminished mental capacity is not a defense in civil cases.

Special Legal Rules for Caregivers And Institutionalized Patients

Many states are following a trend disallowing lawsuits by caregivers against patients who have been institutionalized because of their inability to control their actions and behaviors.

The rationale has two parts: First, these patients need special care in special settings. Their ability to get care could be jeopardized by allowing such lawsuits. A patient might have vital personal assets depleted by paying a civil judgment.

Secondly, the courts recognize that caregivers who accept employment with Alzheimer's and other dementia and psychiatric patients recognize and voluntarily accept special risks.

Caregivers should have the training to work with these patients. Institutions should screen employees to ensure they can work with this special population and offer training that may be necessary.

No Contributory Negligence

Although it was not an issue in this case, the court pointed out the same trend toward recognizing diminished mental capacity in civil suits involving institutionalized patients means that caregivers cannot claim their cognitively-challenged patients are negligent when caregivers or institutions are sued for negligence.

For example, if a patient elopes or jumps from the roof it cannot be claimed that it was the patient's own fault. **Berberian v. Lynn, 355 N.J. Super. 210, __ A. 2d. __, 2002 WL 31557027 (N.J. App., November 20, 2002).**

Hospice Care / Medicare Part A: New Regulations For Admissions, Discharges.

PART 418--HOSPICE CARE

Subpart B-Eligibility, Election and Duration of Benefits

2. In Sec. 418.21, paragraph (a) is revised to read as follows:

Sec. 418.21 Duration of hospice care coverage--Election periods.

(a) Subject to the conditions set forth in this part, an individual may elect to receive hospice care during one or more of the following election periods:

(1) An initial 90-day period;

(2) A subsequent 90-day period; or

(3) An unlimited number of subsequent 60-day periods.

* * * * *

3. In Sec. 418.22, paragraphs (a) and (b) are revised to read as follows:

Sec. 418.22 Certification of terminal illness.

(a) Timing of certification--(1) General rule. The hospice must obtain written certification of terminal illness for each of the periods listed in Sec. 418.21(a), even if a single election continues in effect for an unlimited number of periods, as provided in Sec. 418.24(c).

(2) Basic requirement. Except as provided in paragraph (a)(3) of this section, the hospice must obtain the written certification before it submits a claim for payment.

(3) Exception. If the hospice cannot obtain the written certification within 2 calendar days, it must obtain an oral certification within 2 calendar days and the written certification before it submits a claim for payment.

(b) Content of certification. Certification will be based on the physician's or medical director's clinical judgment regarding the normal course of the individual's illness. The certification must conform to the following requirements:

(1) The certification must specify that the individual's prognosis is for a life expectancy of 6 months or less if the terminal illness runs its normal course.

(2) Specific clinical findings and other documentation that support the medical prognosis must accompany the certification and must be filed in the medical record with the written certification as set forth in paragraph (d)(2) of this section.

* * * * *

4. In Sec. 418.24, paragraph (c) is revised to read as follows:

Sec. 418.24 Election of hospice care.

* * * * *

(c) Duration of election. An election to receive hospice care will be considered to continue through the initial election period and through the subsequent election periods without a break in care as long as the individual--

(1) Remains in the care of a hospice;

(2) Does not revoke the election under the provisions of Sec. 418.28; and

(3) Is not discharged from the hospice under the provisions of Sec. 418.26.

* * * * *

5. New Section. Sec. 418.25 and 418.26 are added to read as follows:

Sec. 418.25 Admission to hospice care.

(a) The hospice admits a patient only on the recommendation of the medical director in consultation with the patient's attending physician, if any.

(b) In reaching a decision to certify that the patient is terminally ill, the hospice medical director must consider at least the following information:

(1) Diagnosis of the terminal condition of the patient.

(2) Other health conditions, whether related or unrelated to the terminal condition.

(3) Current clinically relevant findings supporting all diagnoses.

On November 22, 2002 the Centers for Medicare & Medicaid Services (CMS) announced new regulations for admission to and discharge from hospices covered by Medicare Part A.

Admissions to hospice care under Medicare Part A now require a medical certification from the hospice's medical director in consultation with the patient's treating physician.

The medical certification must document the medical director's diagnosis of the terminal condition, other health conditions, whether related or unrelated to the terminal condition, and the current clinically relevant findings supporting all diagnoses.

CMS has indicated it has no concern about the source of a patient's referral to hospice care or to a particular hospice as long as the new regulations are adhered to for medical certification.

Discharge from a hospice for cause, that is, when a patient is acting out inappropriately and threatening the delivery of care, must follow procedures outlined in the new regulations.

FEDERAL REGISTER, November 22, 2002
Pages 70363 – 70373

Hospice Care / Medicare Part A: New Regulations For Admissions, Discharges.

Sec. 418.26 Discharge from hospice care.

(a) Reasons for discharge. A hospice may discharge a patient if--

(1) The patient moves out of the hospice's service area or transfers to another hospice;

(2) The hospice determines that the patient is no longer terminally ill; or

(3) The hospice determines, under a policy set by the hospice for the purpose of addressing discharge for cause that meets the requirements of paragraphs (a)(3)(i) through (a)(3)(iv) of this section, that the patient's behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

The hospice must do the following before it seeks to discharge a patient:

(i) Make a serious effort to resolve the problem(s) presented by the patient's behavior or situation.

(ii) Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services.

(iii) Document the problem(s) and efforts made to resolve the problem(s) and enter this documentation into its medical records.

(iv) Obtain a written physician's order from the patient's attending physician and hospice medical director concurring with discharge from hospice care.

(b) Effect of discharge. An individual, upon discharge from the hospice during a particular election period for reasons other than immediate transfer to another hospice--

(1) Is no longer covered under Medicare for hospice care;

(2) Resumes Medicare coverage of the benefits waived under Sec. 418.24(d); and

(3) May at any time elect to receive hospice care if he or she is again eligible to receive the benefit.

(c) Discharge planning. (1) The hospice must have in place a discharge planning process that takes into account the prospect that a patient's condition might stabilize or otherwise change such that the patient cannot continue to be certified as terminally ill.

(2) The discharge planning process must include planning for any necessary family counseling, patient education, or other services before the patient is discharged because he or she is no longer terminally ill.

6. In Sec. 418.28, paragraph (b)(1) is amended by adding the following sentence at the end of the paragraph.

Sec. 418.28 Revoking the election of hospice care.

* * * * *

(b) * * *

(1) * * * If a signed revocation is not obtainable by the hospice for a discharge under Sec. 418.26(a)(3), the requirement of the section may be waived.

Subpart F--Covered Services

7. In Sec. 418.202, the introductory text is republished, and a new paragraph (i) is added to read as follows:

Sec. 418.202 Covered services.

All services must be performed by appropriately qualified personnel, but it is the nature of the service, rather than the qualification of the person who provides it, that determines the coverage category of the service. The following services are covered hospice services:

* * * * *

(i) Effective April 1, 1998, any other service that is specified in the patient's plan of care as reasonable and necessary for the palliation and management of the patient's terminal illness and related conditions and for which payment may otherwise be made under Medicare.

Subpart G--Payment for Hospice Care

8. Section 418.301 is amended by adding a new paragraph (c) to read as follows:

Sec. 418.301 Basic rules.

* * * * *

(c) The hospice may not charge a patient for services for which the patient is entitled to have payment made under Medicare or for services for which the patient would be entitled to payment, as described in Sec. 489.21 of this chapter.

9. Section 418.302 is amended by adding a new paragraph (g) to read as follows:

Sec. 418.302 Payment procedures for hospice care.

* * * * *

(g) Payment for routine home care and continuous home care is made on the basis of the geographic location where the service is provided.

(Catalog of Federal Domestic Assistance Program No. 93.773, Medicare--Hospital Insurance; and Program No. 93.774, Medicare-- Supplementary Medical Insurance)

FEDERAL REGISTER, November 22, 2002
Pages 70363 – 70373

Editor's Note: The US Government does not place copyright restrictions on Federal regulations. Just as we have freedom to reproduce and distribute these materials, anyone else can reproduce and distribute these materials from our newsletter.

We have placed the full text of the Centers for Medicare & Medicaid Services November 22, 2002 announcement on our website at http://www.nursinglaw.com/hospices.pdf.

Or go to http://www.access.gpo.gov/su_docs/fedreg/a021122c.html.

Panic Disorder/Agoraphobia: Court Upholds Home Health Nurse's Suit For Defamation, Disability Discrimination, Retaliation.

A home health nurse had been diagnosed with panic disorder with agoraphobia in 1983. Her condition was in remission for a length of time, but her symptoms resurfaced in 1996.

Symptoms Not Controlled By Medication

The nurse had sought treatment from a number of psychologists and psychiatrists, but she declined to take the medications they recommended for fear of addiction.

Instead, the nurse was attempting to self-manage her disorder by taking Fridays off during the winter months, forcing herself to go to public places during the day when fewer people would be around and by making an overall effort to become acclimated to leaving her home.

This Nurse Has A Disability

The Federal courts have chosen to overrule the Equal Employment Opportunities Commission's (EEOC) regulations on psychiatric disabilities.

The EEOC's interpretation of the intent of Congress in enacting the Americans With Disabilities was that all psychiatric conditions are to be considered legal disabilities if they have the tendency to substantially impair a major life activity, even if the impairment is being controlled by the use of medication.

The Federal courts have said, to the contrary, that a psychiatric disability that is being controlled by medication such that it does not substantially impair a major life activity is not a disability. Cases have said that nurses whose depression is being controlled by medication are not disabled.

The upshot for this nurse's employer was that she was legally disabled and was entitled to reasonable accommodation.

Reasonable Accommodation Was Refused

According to the Court of Appeals of Minnesota, the nurse's employer was at first willing to accommodate her condition by helping her with her self-management program, but changed its attitude and insisted she work full time with no flexibility, any hours her employer demanded.

The elements of defamation require the victim to prove that the statement was false, that it was communicated to someone besides the victim and that it tended to harm the victim's reputation and lower the victim in the estimation of the community.

True statements are not defamatory.

There is a qualified privilege to communicate defamatory statements under some circumstances.

Because of the stake employers have in protecting themselves and the public from dishonest and incompetent employees, communications between employers' agents and between employers and potential employers made in the course of investigating and punishing employee misconduct have a qualified privilege.

The qualified privilege requires a reasonably thorough investigation. An employer cannot rest on accusations and second-hand hearsay and expect protection from the courts from a defamation lawsuit.

COURT OF APPEALS OF MINNESOTA
November 19, 2002

The nurse hired an attorney who was in the process of presenting her disability discrimination claim to a state human-rights agency when she was fired.

Circumstances of Termination Were Not Investigated

The nurse did not meet a client's disabled child at the school bus as her supervisor wanted. Her supervisor claimed she violated a direct order, which would be abandonment of a patient and grounds for termination. The nurse claimed she was only asked and had the option to decline.

Then the supervisor told a potential new employer the nurse had been fired for abandonment of a patient. The nurse claimed, and the court agreed, that was grounds to sue for defamation.

No Qualified Privilege Against This Defamation Lawsuit

Ordinarily a former employer has the right to communicate derogatory information to potential employers. A qualified privilege against being sued for defamation exists when an employer's statement that turns out to be false and defamatory was preceded by a reasonably thorough investigation.

Here, however, according to the court, the supervisor did not interview the nurse or her co-workers to see what really happened before terminating the nurse.

Employer Retaliation Was The Motive

The only rationale the court could see behind the termination was retaliation for filing a disability discrimination claim.

The court pointed out retaliation is grounds for a lawsuit whether or not an employee's disability discrimination claim is valid. This nurse did have a right to complain about reasonable accommodation being refused, but that was not necessary to sue for retaliation. **Kuechle v. Life's Companion P.C.A., Inc., 653 N.W. 2d 214, 13 A.D. Cases 1396, 2002 WL 31554566 (Minn. App., November 19, 2002).**

Home Health: CMS Proposes To Open Referral Process To Public Scrutiny.

On November 22, 2002 the Centers for Medicare & Medicaid Services (CMS) proposed to add the following language to the Medicare regulations for hospitals that refer patients to home health agencies (HHA's):

PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS

Sec. 482.43 Condition of participation: Discharge planning.

* * * * *

(c) * * *

(6) If a hospital refers a Medicare beneficiary to an HHA or another entity in which the hospital has a reportable financial interest, or the HHA or other entity has a reportable financial interest in the hospital, CMS will make available to the public the following information:

(i) The name of the hospital, HHA, or other entity and the nature of the financial interest to the hospital.

(ii) The number of beneficiaries whom the hospital discharged and identified as requiring home health services.

(iii) The percentage of the referrals in paragraph (c)(6)(ii) of this section in which the hospital had financial interest in the HHA, or the HHA had a financial interest in the hospital.

CMS will accept public comments until January 21, 2003 before deciding whether to issue mandatory regulations.

The intent is to open up to public scrutiny the financial interests hospitals may have in the home health agencies to whom the hospitals refer their patients.

For more detail go to http://www.nursinglaw.com/HHAreferrals.pdf.

FEDERAL REGISTER, November 22, 2002
Pages 70373 – 70376

Patient Falls Out Of Bed: Court Says Nurse Not Responsible When Family Member Lowers Bed Rails.

A patient fell at home. Her head laceration was treated in the emergency room and she was kept in the hospital for observation. Her admitting note stated she suffered from Alzheimer's disease and syncope.

At 3:30 a.m. a nurse's aide found the patient on the floor in her room with the two bottom bed rails down.

Nursing Documentation

The Court of Appeal of Louisiana went through the events leading to the patient's fall as reflected in the nursing notes. The court pointed out the medical review panel convened for this case had described the nursing notes as appropriate and thorough.

Initial Assessment

The initial nursing assessment indicated the patient answered the nurse's questions appropriately but she was disoriented to time, person and place.

Teaching Done

The nurse noted a family member was present (a fifteen year-old grandniece). She and the patient were instructed and encouraged in the use of the call bell to summon assistance.

All four bed rails were noted to be up at the point the teaching was completed.

Patient Checked Frequently

The nurse's note for 10:00 p.m. stated the nurse's assessment of the patient was unchanged and all four bed rails were up.

At 12:00 p.m. the nurse noted the doctor was making his rounds and that new orders were written.

At 3:00 a.m. the nurse noted the patient was asleep.

Patient Found on Floor

Five minutes after the aide found the patient on the floor the nurse made a complete chart entry, starting with the fact the aide found the patient on the floor when she checked on the patient.

The nurse assessed the patient and charted the patient was not complaining of pain and could bear weight well.

The nurse noted the granddaughter (sic) said she was present when she fell but did not hear her fall.

The nurse noted the bottom two bed rails were down. When questioned the granddaughter (sic) stated she had put them down earlier.

An incident report was prepared on the spot, the court said.

Since there was no apparent injury the doctor was not informed of the fall until 7:00 a.m. He found a fracture of the femoral head which required surgery.

Jury Decides Nurse Was 20% At Fault
Verdict Overturned On Appeal

The jury ruled the hospital 20% responsible and the family member 80% responsible. Of the $200,000 reckoned as appropriate compensation for such an injury only $40,000 was the hospital's responsibility. The Court of Appeal of Louisiana overturned the verdict, placing no percentage of fault on the nurse.

Standard of Care

The Court of Appeal recited the familiar legal rule that a verdict in a professional malpractice case must be based on expert testimony establishing the standard of care for the nurse and showing that the standard of care was breached.

The patient's expert witness was silent on the issue of a nurse having to instruct a family member not to lower the bed rails after they have been raised by the nurse in the family member's presence.

Although a hospital does not have the legal burden to disprove allegations of negligence, the hospital's expert did state that teaching family members to leave the bed rails alone is not generally done. **Thomas v. Southwest Louisiana Hospital Association, __ So. 2d __, 2002 WL 31761431 (La. App., December 11, 2002).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Home Health: Aides Ruled Agency's Employees, Not Clients' Employees.

The Court of Appeals of Arkansas, in an opinion that has not been designated for publication, ruled a state agency was correct in holding a home health agency liable for unemployment taxes on the wages of home health aides placed in the agency's clients' homes.

That is, the aides were ruled to be employees of the home health agency, not employees of the clients.

The home health agency required its aides to sign an agreement that they were independent contractors, did not withhold income taxes from their wages and did not pay unemployment taxes. The home health agency simply took a $2 per hour fee for every hour the aides worked in its clients' homes on top of the $6 to $10 per hour the aides were paid.

The court found this evidence unpersuasive, and ruled the aides nevertheless were agency employees rather than independent contractors.

Right of Control

The first test for the existence of an employment relationship is who has the right of control over the worker in carrying out work tasks.

In this case the home health agency accepted and disbursed Medicaid funds and had another firm's nurses evaluate clients clinically, write care plans and supervise the aides in carrying out the care plans. However, the court ruled, the home health agency had ultimate legal responsibility for control over how the work was carried out by the aides.

The aides were not free from control and direction in carrying out the work as true independent contractors would be.

Usual Course of Employer's Business

The court also pointed out the aides were performing services within the usual course of the business of the home health agency, a legal indication they are employees.

No Independent Trade or Business

Finally, the court noted that the aides were not engaged in an established independent trade, occupation, profession or business, which also tends to prove they are employees rather than independent contractors. **Superior Senior Care, Inc. v. Director of Employment Security, 2002 WL 31518302 (Ark. App., November 13, 2002).**

Restraints: Court Throws Out Nurse's Testimony, Had No Specific Expertise In Use Of Restraints.

A patient sued the hospital after she broke her hip. She fell while trying to work her way out of a belt restraint and get out of bed in a state of confusion.

The patient died from unrelated causes before the suit came to trial and the lawsuit was continued by the personal representative of her probate estate on behalf of her family who stood to inherit the assets of her estate.

The Supreme Court of Alabama upheld the trial court's decision to dismiss the case for lack of evidence.

The evidence was lacking because the trial court threw out the testimony of the nursing expert the patient's personal representative's attorneys retained for the case. The court ruled she did not have sufficient qualifications.

The patient's nursing expert is not qualified to testify in this case.

She is on the staff at the university's nursing school, but she has not worked in a hospital for more than twenty years, has not worked anywhere as a nurse in eight years, has never researched or written about restraints and has never used the belt restraint at issue in this case.

SUPREME COURT OF ALABAMA
November 27, 2002

Specific Expertise Was Lacking

To testify as an expert in a healthcare negligence case a witness must have expertise in the same professional discipline and experience in the same care setting as the defendant. Nurses are recognized as experts when nursing negligence is the issue.

However, in this case the specific question was whether the patient was properly restrained. The court wanted an expert with specific knowledge as well as specific experience in the use of restraints with geriatric acute-care hospital patients. The plaintiff's witness had no such knowledge or experience and was ruled ineligible to testify as an expert. **Tuck v. Healthcare Authority of the City of Huntsville, __ So. 2d __, 2002 WL 31663594 (Ala., November 27, 2002).**