LEGAL EAGLE EYE NEWSLETTER

January 2004 — *For the Nursing Profession* — Volume 12 Number 1

Wrong Drug Ordered: Nurses Must Intervene.

A forty-six year-old man had been diagnosed and had started taking Tambocor for ventricular tachycardia two years before he came to the hospital's emergency room stating his heart rate would not slow down even though he had taken his medication. He was conscious and had no chest pain.

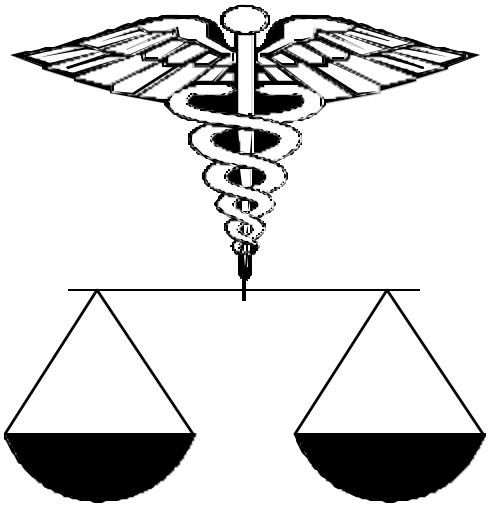
An EKG confirmed it was ventricular tachycardia. The ER physician ordered lidocaine and bretylium and then phoned the on-call cardiologist when those two drugs did not work.

After getting off the phone with the cardiologist the ER physician ordered 5 mg of verapamil. It was administered by an EMT working in the ER as a nursing technician.

The ER nurse and the house nursing supervisor both saw that the EMT was about to give verapamil. All three knew it was contraindicated for ventricular tachycardia because in ventricular tachycardia it can cause hemodynamic collapse, but the two nurses did nothing and the EMT went ahead.

Two minutes later the patient's blood pressure crashed and he arrested. He was revived but has permanent brain damage and no independent motor function or capacity for speech. The jury's verdict was $13.1 million.

(Continued on page 6)



A nurse has a legal duty to refuse to act and to take it up through the nursing chain of command when the nurse has serious questions about a medication involving an extreme risk of harm.

A nursing supervisor must intervene when a nurse complains about an apparently erroneous and potentially dangerous medication order.

COURT OFAPPEALS OF TEXAS
November 20, 2003

Nursing Home Resident's Fall: Negligence Suit Allowed.

The sixty-two year-old resident was six feet one inch tall and weighed 310 pounds. He was developmentally disabled, with a mental age of seven years. He had lost the use of one leg from numerous strokes.

His plan of care expressly called for two aides to assist in transferring him from his wheelchair to his shower chair. Furthermore, according to his plan of care, the transfer was to be done in his room and he was to be wheeled to the shower in his shower chair, as the shower area was too narrow and confining for the two-person-assisted transfer to be done there.

Nevertheless, one aide alone attempted to transfer him in the shower room by propping him against the wall on his good leg. He fell and fractured his good leg.

The Court of Appeal of Louisiana ruled there were grounds for a negligence lawsuit. In a case like this aides have no discretion to depart from the plan of care that has been adopted by the professional nursing staff for the resident's safety. **Jordan v. Stonebridege, L.L.C., __ So. 2d __, 2003 WL 22799032 (La. App., November 25, 2003).**

Inside this month's issue ...

January 2004

Nurse As Civil Juror: Court Finds No Misconduct.

A husband and wife filed suit against various parties after the wife slipped and fell and fractured her tibial plateau while a patron at a riverboat gambling casino. Dissatisfied with the verdict of only $55,000, the couple appealed. Among other allegations they claimed juror misconduct by a nurse on their jury.

A juror who has specialized knowledge in a certain field is not supposed to use that knowledge or share that knowledge with other jurors sitting on a civil case to influence the jurors in reaching a verdict.

Introduction of extraneous information on top of the evidence presented in court is considered prejudicial to the civil court's processes.

COURT OF APPEALS OF INDIANA
December 8, 2003

The jury awarded nothing for future medical expenses, even with solid evidence she needed future surgeries costing $107,000, because the nurse/juror told the other jurors Medicare would cover it.

The Court of Appeals of Indiana agreed that jurors are not supposed to use their specialized knowledge they bring with them to influence the jury's decision.

However, it is common knowledge, not specialized knowledge among healthcare professionals, that Medicare pays bills for eligible persons even if they have the means to pay. Furthermore, a juror with specialized knowledge is supposed to be excused and if not commits no wrongdoing sharing his or her knowledge and experience. **Evans v. Buffington Harbor River Boats, LLC, __ N.E. 2d __, 2003 WL 22883320 (Ind. App., December 8, 2003).**

Patient Falls: Court Sees It As Malpractice, Dismisses Case.

A nurse stood the patient on her feet while assisting her to get dressed so that she could be discharged from the facility where she had been undergoing rehab from a head injury.

The patient fell and fractured her leg. She sued for negligence. The local county circuit court judge dismissed her case. The Court of Appeals of Michigan agreed, in an unpublished opinion.

The act of assisting a patient in this patient's condition, i.e., recovering from a head injury and bedridden for a prolonged period of time, to stand or to move from a bed to a chair, requires training and the exercise of professional judgment, both to minimize the patient's discomfort and to guard against further injury.

COURT OF APPEALS OF MICHIGAN
UNPUBLISHED OPINION
December 2, 2003

A nurse is not necessarily negligent just because a patient falls.

While a patient at the rehab facility there were physician's orders for the nurses to have the patient get out of bed, have her sit in her chair, have her learn to ambulate with a walker and have her resume her own self-care. In assisting the patient to stand and dress the nurse was performing a professional nursing intervention. Therefore, there must be expert witness testimony as to the nursing standard of care and breach of the standard of care by the nurse. The patient in this case was unable to provide an expert so the case had to be dismissed. **Lewandowski v. Mercy Memorial Hosp. Corp., 2003 WL 22850024 (Mich. App., December 2, 2003).**

Patient Falls: Lawsuit Will Go Forward.

The family members of an eighty-one year-old deceased nursing home resident appealed from the ruling of a medical review panel that exonerated the defendants from liability for the deceased's fall in a nursing home. She was found by her bed with a broken hip

The Appeals Court of Massachusetts, in an unpublished opinion, overruled the review panel and said the family will get their day in court to present their evidence before a judge and jury and ask for damages. **Danna v. Marina Manor, Inc., 2003 WL 22888936 (Mass. App., December 8, 2003).**

The family of the deceased obtained a letter from a doctor stating his expert medical opinion.

His expert medical opinion was that the nursing home staff breached the acceptable standard of care, which caused her fall, which contributed to her premature death.

They knew she required supervision walking due to an unsteady gait and noncompliance with walker usage, and because she fell at home before admission.

There was a legal duty to use a Posey vest restraint to keep her in bed and to observe her more closely.

The nursing staff needed and should have sought a medical order for restraints, for the resident's safety.

APPEALS COURT OF MASSACHUSETTS
UNPUBLISHED OPINION
December 8, 2003

Labor And Delivery: Patient Not Required To Prove How Burn Injury Occurred During Epidural, Lawsuit Goes Forward Under *Res Ipsa Loquitur.*

A patient sued the hospital and her physician for malpractice for a burn injury she sustained while hospitalized to give birth.

The hospital and the physician asked the court to dismiss the case because the patient was unable to specify how the burn injury happened or which of her caregivers, the nurses, staff physicians, her physician, etc., was actually to blame.

The patient's lawyers countered by arguing for application of the legal rule of *res ipsa loquitur*, a phrase from the Latin meaning, "The thing speaks for itself."

The New York Supreme Court, Appellate Division, agreed with the patient's lawyers and allowed the case to go forward.

Speculation As To Cause of Injury

The patient discovered the burn injury only after awakening from a sedative-induced sleep. The injury apparently occurred while she was numbed from the waist down by an epidural anesthetic.

The patient's lawyers speculated it was probably the overhead examination lamp in the labor and delivery examination room that caused the burn injury, but that was only speculation.

Infliction of a blistering burn on the inner portion of the patient's right knee during or shortly after a vaginal examination and administration of an epidural anesthetic is an event that a jury could reasonably infer would not happen in the absence of negligence by the patient's caregivers.

Further, any potential cause of the burn was within the exclusive control of the defendant caregivers.

The defendants together exercised concurrent control over the examination room and the medical equipment.

The patient was unconscious from her medications and could not identify the person who caused her injury.

The doctrine of res ipsa loquitur applies here.

NEW YORK SUPREME COURT
APPELLATE DIVISION
November 17, 2003

Numerous employees of the hospital as well as independent-contractor physicians were in and out of the room during the two hours the patient was asleep, making it virtually impossible to determine exactly who let the lamp touch her or come close to her or left it there, if the lamp was what caused the injury.

Res Ipsa Loquitur

The courts apply the rule of *res ipsa loquitur* to give an injured patient/victim the benefit of the doubt in these situations. The classic case for *res ipsa loquitur* is a general-anesthetic patient in a hospital operating room who awakes to find he or she has been injured but with no way to prove exactly what happened, how it happened or who did it, things a plaintiff is normally expected to prove in a civil negligence lawsuit.

The court ruled that a hospital patient would normally not be injured in this manner without someone committing negligence.

The whole scenario was exclusively within the control of the defendants collectively during the whole time the injury could have occurred.

No third parties or the patient herself could have caused or contributed to it.

The caregivers will have to sort it out or all will face joint liability. **Rosales-Rosario v. Brookdale University Hospital and Medical Center, __ N.Y.S.2d __, 2003 N. Y. Slip Op. 18447, 2003 22717881 (N.Y. App., November 17, 2003).**

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Resident Elopements, Assaults: Court Finds Noncompliance With Medicare/Medicaid Regulations, Allows Civil Penalty To Stand.

The US Circuit Court of Appeals for the Sixth Circuit, in an opinion that will not be officially published in the Federal Reporter, agreed with US Department of Health and Human Services inspectors and with inspectors from the State of Ohio, that a state of immediate jeopardy to residents existed at a skilled nursing facility and approved imposition of a daily penalty of $3,050 for an eleven-day period.

State of Immediate Jeopardy

State of immediate jeopardy is the term used for the most serious level of deficiency that can be found at a Medicare/Medicaid-participating facility.

A daily civil monetary penalty of $3,050 – $10,000 can be imposed on a facility for the time during which inspectors determine a state of immediate jeopardy exists or existed.

Resident Elopements / Assaults

The skilled nursing facility housed forty-three persons, two-thirds of whom displayed behavioral signs of dementia. More than half were diagnosed with Alzheimer's, advanced Parkinson's, organic brain syndrome, alcohol dependency, schizophrenia, mood disorders, etc.

Acting on a complaint from an employee, state and Federal inspectors visited the facility over a two-week period while resident elopements and assaults occurred.

The inspectors faulted the facility in many respects.

An Alzheimer's patient with an alarm bracelet got out of the building several times. A surveillance camera was installed and pointed at the fence he would climb as he fled, but still he got off the premises and wandered in the cold without a coat or shoes. Apparently the staff were not trained to know how the alarm and surveillance equipment worked.

Another resident with organic brain disorder and a history of assaults assaulted his roommate. They tried to alter his medication, but he received no psychological attention, was put back in with the same resident and assaulted him again.

An individual, now an Alzheimer's patient at the facility, had previously often visited her husband there. Another visitor, who recognized her as a visitor, courteously opened the front door for her and she walked away as no staff were looking.

Two other residents, one with Alzheimer's and one with advanced Parkinson's and schizophrenia, did not receive adequate monitoring of their medication levels. Each became agitated and combative. One broke a window and eloped. The other went on a rampage attacking other residents, then tried to hang himself in his room and had to be discharged to the VA psych ward.

Federal regulations for skilled nursing facilities state that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being in accordance with the comprehensive assessment and plan of care.

Each resident must receive adequate supervision and assistance devices to prevent accidents.

Resident elopement and resident assaults upon other residents are considered accidents for purposes of the Federal regulations for skilled nursing facilities.

A deficiency exists, for which civil monetary penalties can be imposed, when such accidents are permitted to occur.

It is not appropriate to split hairs whether an intentional act by a resident can be considered an accident, or whether what would be intentional for one person would not be intentional for a cognitively impaired dementia patient.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
November 17, 2003

Deficiencies Found to Exists

By law a deficiency exists when a facility provides care that is substandard, that is, care that falls beneath the Medicare/Medicaid participation requirements.

In this case the court agreed that the facility was required to provide security precautions such as closer supervision of residents that were known to be at risk for flight or violence and more effective electronic and premises perimeter security measures.

The residents were entitled to better physical and chemical restraints for their own safety, including better psychological and psychiatric evaluation and treatment and closer monitoring of the effectiveness of their medication regimens.

Nursing homes are often able successfully to defend common-law negligence lawsuits when residents are injured eloping and then sue or have family members sue on their behalf. However, the court pointed out the administrative standards for Medicare/Medicaid compliance are much stricter than the common-law negligence standard. The case precedents from the common law are not applicable. **Woodstock Care Center v. Thompson, 2003 WL 22718244 (6th Cir., November 17, 2003).**

STANDARDS FOR LONG TERM CARE FACILITIES (No copyright as to US Govt. works.)

42 C.F.R.§ 483.25 Quality of care.

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

(a) Activities of daily living. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to--

(i) Bathe, dress, and groom;

(ii) Transfer and ambulate;

(iii) Toilet;

(iv) Eat; and

(v) Use speech, language, or other functional communication systems.

(2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section; and

(3) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

(b) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident--

(1) In making appointments, and

(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

(d) Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that--

(1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary and

(2) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(e) Range of motion. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and

(2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(f) Mental and Psychosocial functioning. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem, and

(2) A resident whose assessment did not reveal a mental or psychosocial adjustment difficulty does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

(g) Naso-gastric tubes. Based on the comprehensive assessment of a resident, the facility must ensure that--

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso-gastric tube unless the resident's clinical condition demonstrates that use of a naso-gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

(h) Accidents. The facility must ensure that--

(1) The resident environment remains as free of accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(i) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident--

(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and

(2) Receives a therapeutic diet when there is a nutritional problem.

(j) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(k) Special needs. The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

(2) Parenteral and enteral fluids;

(3) Colostomy, ureterostomy, or ileostomy care;

(4) Tracheostomy care;

(5) Tracheal suctioning;

(6) Respiratory care;

(7) Foot care; and

(8) Prostheses.

(l) Unnecessary drugs--

(1) General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(i) In excessive dose (including duplicate drug therapy); or

(ii) For excessive duration; or

(iii) Without adequate monitoring; or

(iv) Without adequate indications for use; or

(v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(vi) Any combinations of the reasons above.

(2) Antipsychotic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that--

(i) Residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and

(ii) Residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.

(m) Medication Errors--The facility must ensure that--

(1) It is free of medication error rates of five percent or greater; and

(2) Residents are free of any significant medication errors.

Contraindicated Medication Ordered By Physician: Court Defines Nurses' Legal Duty To Intervene To Protect Patient (Continued).

(Continued from page 1)

The Court of Appeals of Texas looked at the case from several different angles, all of which supported the jury's substantial verdict in the patient's favor.

Verapamil Contraindicated for Ventricular Tachycardia

According to the court, verapamil can be used in treatment of certain types of tachycardia, that is, tachycardia which can be identified as supraventricular, left or right bundle branch block tachycardia or idiopathic ventricular tachycardia. Tachycardia that is amenable to verapamil therapy can be identified with a narrow-complex PSVT pattern on EKG.

However, according to the court, the legal standard of care for nurses and non-specialist physicians is to presume that all tachycardia is garden-variety ventricular tachycardia, i.e., wide-QRS ventricular tachycardia, for which verapamil can cause devastating consequences.

Only when tachycardia is known with certainty to be non-ventricular in origin may verapamil be given. The court ruled in practical terms for nurses that means never for a ventricular tachycardia patient.

Nursing Standard of Care
ACLS Training

The emergency room staff nurse was certified in Advanced Cardiac Life Support and the house supervisor had been certified but had allowed her certification to lapse.

Both were familiar with the accepted algorithms for emergency cardiac medications, that is, that verapamil basically was always contraindicated and never to be used in ventricular tachycardia.

EMT Working As Nursing Tech

The court faulted the hospital for allowing a non-nurse emergency medical technician to administer medications. He was the first such person to work at the hospital. He should have had a job description that expressly told him he was not to give medications, the court said.

A nurse is responsible for knowing the rationale for and the effects of any medication the nurse is ordered by a physician to administer.

A nurse must question any medication apparently ordered in error prior to administering the drug.

If a nurse has any reason to doubt or question the care provided to a patient or believes that appropriate consultation is needed and has not been obtained, the nurse must call this to the attention of the nurse's supervisor who in turn may refer the matter to the house nursing supervisor.

The house nursing supervisor may bring the matter to the attention of the attending physician, medical department chair, medical chief of staff or chief operating officer if warranted and appropriate.

A nurse consulting with a supervisor about an order should not delay giving a medication or starting a treatment. All questions from staff nurses about medical orders must start up the nursing chain of command without delay.

COURT OF APPEALS OF TEXAS
November 20, 2003

Nurse's Duty to Intervene
Apparently Erroneous
Physician's Order

Nurses have the legal duty to question a physician's order that is apparently erroneous and if erroneous poses a risk of immediate serious harm to the patient.

The court approved the hospital's written protocol to this effect, while holding the hospital liable nonetheless because the nurses did not follow the protocol.

A staff nurse who has reservations about a physician's order must consult with a nursing supervisor before going ahead with the order.

A nursing supervisor in a hospital setting must either reassure the staff nurse to go ahead or report the problem to the house supervisor.

According to the court, it is at the level of house supervisor that confrontation with the treating physician is best to occur, or, if that is not fruitful, the matter is to be taken over the treating physician's head up the medical chain of command.

A nurse must act without delay. It is possible the order is correct and can be explained and should be carried out. Maybe the nurse simply does not understand what is going on and it is an opportunity for a learning experience.

However, if it actually comes down to it, according to the court, a nurse has the legal and moral duty to refuse to give a medication or carry out any order from a physician the nurse knows is wrong and will likely cause serious harm to a patient.

Failure To Intervene
Nursing Negligence

As in this case, there are separate legal ground for the patient to sue for nursing malpractice, above and beyond the basic malpractice case against the physician, when a nurse knows something is wrong and goes along or does nothing to stop it.

Columbia Medical Center of Las Colinas v. Bush, __ S.W. 3d __, 2003 WL 22725001 (Tex. App., November 20, 2003).

Stress/Disability Discrimination: Nurse's Case Dismissed.

A recent case from the US District Court for the Southern District of New York illustrates how difficult it can be for a nurse to succeed with a disability discrimination lawsuit against an employer or former employer.

Job Stress
Difficulty Working With Supervisor

Job stress as a general rule does not fall under the legal definition of a disability as contemplated by the US Americans With Disabilities Act and the accompanying regulations of the Equal Employment Opportunity Commission. The same is true for difficulty working with a particular supervisor or co-worker, assuming there is no harassment going on, which is a separate issue.

The legal rationale is twofold. First, to be disabled a person must be unable to perform a broad class of jobs in the workforce. Inability to work as a nurse on one particular unit, even to work as a nurse at all, is not a disability if other options are open. Second, even if the person has a disability the person must be able to do the job in question, with or without reasonable accommodation.

The nurse in this case filed suit claiming she had a stress-related irritable bowel syndrome which completely prevented her from working for a particular supervisor, and requested reasonably accommodation by being allowed to work elsewhere.

The court disallowed her claim. First, the nurse admitted her stress-related illness did not prevent her from doing a broad class of jobs, only one particular job with one particular supervisor.

Second, being unable to work for a particular supervisor is not a disability, so there is no obligation to provide reasonably accommodation by transferring the employee. If the employee is unable to work for a particular supervisor without suffering a debilitating stress-related medical condition, the employee is not qualified for the position, the court reasoned. **Benjamin v. N.Y.C. Dept. of Health, 2003 WL 22883622 (S. D. N.Y., December 8, 2003).**

To sue for disability discrimination, a nurse, like any other person, must be able to prove he or she suffers from a physical or mental impairment that substantially limits the nurse in one or more major life activities, or that he or she has a record of such an impairment, or that he or she is regarded by the employer as one who has such an impairment.

To be substantially limited in the major life activity of working, a person must be significantly restricted in the ability to perform either a class of jobs or a broad range of jobs in various classes compared to the average person.

The inability to perform a single, particular job does not constitute a substantial limitation in the major life activity of working.

Even if a nurse has a condition that meets the legal definition of disability as contained in the Americans With Disabilities Act, the nurse must be able to demonstrate that he or she is qualified to perform the essential functions of the position in question, with or without reasonable accommodation.

UNITED STATES DISTRICT COURT
NEW YORK
December 8, 2003

Voyeurism: Court Gives Nursing Home Residents A Reasonable Expectation Of Privacy.

The Court of Appeals of Washington, in an unpublished opinion, has ruled that all areas on the premises of a nursing home, including the dining area, are not public places, but are private places essentially equivalent to a resident's home.

Therefore, it is proper for a nursing home to have a policy to prohibit residents from being photographed without their consent and to prohibit residents incapable of granting consent from being photographed altogether, and to report violators to law enforcement.

It is a violation of the criminal voyeurism statute to photograph a nursing home resident for lascivious purposes who does not or who is not capable of consenting. **State v. Larson, 2003 WL 22766043 (Wash. App., November 24, 2003).**

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LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Discrimination: Court Rules Nurse Not Able To Prove His Case.

A male African-American nurse sued his employer, the US Department of Veterans Affairs, for race discrimination.

After reviewing all the evidence, the US District Court for the Eastern District of Illinois ruled he was not able to prove his case.

Failure to Promote

The court noted in general terms that failure to promote a nurse from one level to the next level of professional advancement can be the basis for a discrimination claim.

Bachelor's Degree Requirement

The hospital annually reviews all nurses with bachelor's degrees in nursing working at the Nurse II level for promotion to Nurse III.

However, according to the court, this nurse, working in a chemical dependency unit, had his bachelor's in psychology and did not have a BSN. In a discrimination case, assuming the hospital's policies were not made up after the fact, the court does not debate or evaluate the soundness of the employer's educational policies for nurse competency and advancement.

Exceptions to BSN Requirement

When an employer has a policy of making exceptions to its policies, those exceptions have to be applied on an even-handed basis.

This hospital reviews all non-BSN Nurse II's every three years for promotion to Nurse III. If a Nurse II can show he or she has been performing at the Nurse III level, promotion can occur notwithstanding the lack of a BSN degree.

However, when a nurse sues for discrimination the nurse has the burden of proof to show what instances of higher-level professional practice were performed to justify promotion and that those instances were brought to the supervisor's attention to be documented in the nurse's file for consideration by the promotion panel.

Or, the nurse has to show that a specified non-minority nurse was granted and exception and promoted despite non-documented higher-level performance or with such performance unilaterally documented by a supervisor, to prove discriminatory treatment has occurred. **Nunnally v. Principi, 2003 WL 22859806 (N.D. Ill., December 2, 2003).**

Latex Allergy: Nurse Must Identify Manufacturer, Or Products-Liability Suit Will Be Thrown Out.

One manufacturer of latex gloves asked to have one nurse's products-liability suit sent back from the multi-district litigation panel to the US District Court for the Western District of Kentucky to consider dismissing the manufacturer from her case.

The court noted there was strong evidence the manufacturer's latex gloves were known to have triggered allergic reactions to latex in a number of persons exposed to the gloves in their workplaces.

However, there is more to a products-liability lawsuit than that, the court pointed out. Without proof that the particular manufacturer's product caused the specific injuries for which a particular nurse is suing for damages, the lawsuit is not viable.

There is evidence that this manufacturer's latex gloves have triggered allergic reactions in many persons.

However, it is fundamental in products-liability cases for the victim to identify the manufacturer's product as the cause of the injury for which damages are sought.

This nurse can only speculate that she was exposed to this particular manufacturer's gloves.

UNITED STATES DISTRICT COURT
KENTUCKY
November 19, 2003

This nurse had only worn one brand of gloves, another manufacturer's brand, at the hospital, the only place she had worked as a nurses aide and then as a registered nurse after nursing school.

This manufacturer's gloves were used in another part of the hospital, the manufacturer conceded.

However, the court accepted the manufacturer's argument it was only speculation that some of its gloves "migrated" to the units where the nurse worked or that airborne contaminants from the gloves over there worked their way into her work environment.

The court gave the nurse's lawyers a ten-week deadline to come up with evidence related to this manufacturer. **Collins v. Ansell Inc., 2003 WL 22769266 (W.D. Ky., November 19, 2003).**