LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

January 2006 Volume 14 Number 1

Narcotics Diversion: Other Nurses Were Not Following Procedures, Case Not Proven.

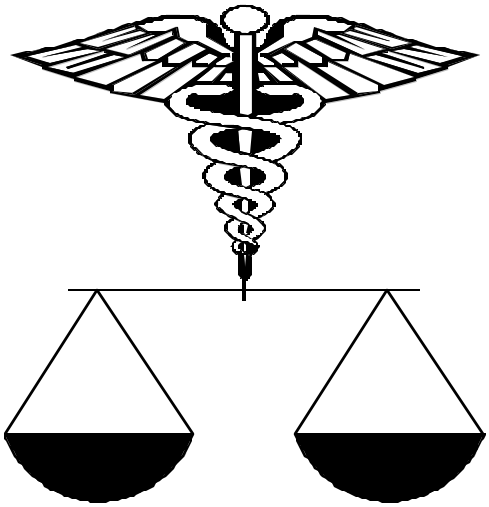
A nurse had been working in critical care for more than twenty-five years and had gained respect for her competence and dedication before suspicions began to gather that she was diverting narcotics.

The hospital had installed equipment in the ICU, described by the US Circuit Court of Appeals for the First Circuit as a "computerized medicine cabinet," to monitor nurses' narcotics. It recorded the nurse's personal keypad code and the patient's data before unlocking to dispense the medication.

Nurses were also required to document their narcotics by jotting down by hand the patient, medication, time, route and dosage on a traditional paper medication administration record.

Discrepancies came to light between the two records for this nurse's patients' narcotics, that is, the electronic data did not always match her handwritten notations on the MAR's.

She was questioned by her superiors. Finding her explanations not credible, they suspended her. She filed a grievance. The arbitrator upheld her grievance and ordered her reinstated. The hospital appealed the arbitrator's ruling but the Federal District Court and the Circuit Court of Appeals both agreed with the arbitrator.



This nurse's termination was without cause. She must be reinstated.

In light of the actual practices going on at the hospital with administration and documentation of narcotics, the discrepancies in this nurse's handling of her narcotics cannot support the conclusion she was guilty of diversion.

UNITED STATES COURT OF APPEALS
FIRST CIRCUIT
November 21, 2005

Discrepancies Existed In Other Nurses' Charting

The court pointed to testimony to the effect that other nurses in the same ICU routinely caught up on their handwritten MAR entries during breaks or at the end of their shifts when they could not always remember the exact medications and dosages given.

There was testimony that nurses would check out narcotics to prepare IV drip bags well in advance of knowing whether or not they would actually need to hang them. Although not a commendable practice, nurses sometimes deviated from physicians' orders and administered narcotic meds through IV lines rather than IM.

There was testimony that the hospital had no established policy for which nurse was to document narcotics in the MAR when two nurses, that is, a trainee and a preceptor, both had responsibility for a patient.

Given the laxity the hospital tolerated in the way other nurses documented their narcotics, the court ruled that discrepancies in the way this particular nurse charted her narcotics were not legally sufficient proof that she was diverting narcotics. **The Mercy Hosp., Inc. v. Mass. Nurses Assn., 429 F. 3d 338 (1st Cir., November 21, 2005).**

Inside this month's issue ...

January 2006

New Subscriptions
See Page 3

Substandard Exam, Charting: Court Upholds Nurse Practitioner's Firing.

According to the New York Supreme Court, Appellate Division, a nurse practitioner was discharged from her employment when she documented normal gynecological findings in a patient's medical chart without actually performing an internal or external gynecological exam.

The state Commissioner of Labor's ruling was that she was terminated for misconduct. The court agreed.

It was an integral part of her job responsibilities not only to perform competent assessments and examinations of her patients, but to document all treatment accurately in the patient's chart.

An employee's failure to comply with the employer's established policies and procedures is misconduct justifying termination for cause especially in healthcare professions where failure to adhere to prescribed procedures can jeopardize the welfare and safety of patients, the court pointed out.

Substandard Examination, Incorrect Chart Note Were Not Mistakes

A simple mistake or an honest error in judgment does not ordinarily rise to the level of misconduct justifying termination.

However, this was a case where the employee in question knowingly made a notation in a patient's chart which did not accurately reflect the fact that a less than thorough examination, substandard practice in and of itself, was the service which was actually rendered.

The nurse practitioner had previously been warned about her job performance and cautioned that another incident could result in her termination, the court also pointed out. **In re Nicholas, __ N.Y.S. 2d __, 2005 WL 3118683 (N.Y. App., November 23, 2005).**

Hospice Care: Revised Medicare Eligibility Rules – Jan. 23, 2006.

Complex revisions to Medicare eligibility rules for hospice care will take effect January 23, 2006.

We have placed the full text of CMS's non-copyrighted November 22, 2005 Federal Register announcement on our website at

http://www.nursinglaw.com/hospicecare.pdf

The new regulations are at the end of the document (Federal Register pages 70546 – 70548, PDF document pages 15 –17).

FEDERAL REGISTER November 22, 2005
Pages 70532 – 70548

On November 22, 2005 the US Centers for Medicare and Medicaid Services (CMS) announced revisions to existing regulations for Medicare coverage and payment for hospice care which will take effect January 23, 2006.

These revisions reflect CMS's current policies on the documentation needed to support a continuing certification of terminal illness and admission to a Medicare hospice and a new requirement that allows for discharge from a hospice for cause under very limited circumstances.

According to CMS, the intent of the new regulations is to expand the hospice benefit periods, improve documentation requirements to support certification and re-certification of terminal illness, provide guidance on hospice admission procedures, clarify hospice discharge procedures and update coverage and payment requirements.

FEDERAL REGISTER November 22, 2005
Pages 70532 – 70548

Bed Rail Entrapment Hazard: Penalty Upheld.

The US Court of Appeals for the Sixth Circuit upheld a civil monetary penalty imposed on a long-term care facility for violation of Federal standards.

According to the court record, the facility raised the half side rails on a resident's bed without adequately assessing the risk of entrapment, failed to investigate and report a resident's injury, allowed a resident to develop an avoidable pressure sore and failed to promote healing of the pressure sore and failed to provide incontinence care to two residents. **Tri-County Extended Care Center v. Leavitt, 2005 WL 3429438 (6th Cir., December 14, 2005).**

No Anti-Embolic Stockings: Hospital Ruled Negligent.

The Court of Appeals of Mississippi accepted the patient's representative's argument that a hospital's circulating nurse is negligent not to ensure that anti-embolic stockings are in use during a surgical procedure when the patient will be under general anesthesia for more than forty-five minutes.

The court dismissed the lawsuit, however, ruling it would only be speculation, with other risk factors present, to say that the patient's death some days after surgery from a pulmonary embolus was related to non-use of the stockings. **Young v. Univ. of Miss. Medical Center, __ So. 2d __, 2005 WL 3112420 (Miss. App., November 22, 2005).**

Nurse Violated Attendance Policy: Retaliation, Disability Discrimination Lawsuit Is Dismissed.

The record of the relevant facts before the US District Court for the Central District of Illinois was very complex.

To summarize, an LPN was hired for a staff position in a nursing home with an existing 15-pound lifting restriction imposed by her physician, which the nursing home agreed in writing it would honor.

The LPN injured her back on the job and filed for workers' compensation. Eventually the employer's medical examiner and her own physician said she could return to work. Their reports were furnished to the employer as part of the LPN's ongoing workers' comp claim.

The LPN was told by letter and follow-up voice mails to contact the director of nursing for a start date to resume her duties. The LPN replied she was seeking other medical treatment for her persistent back pain which she said still prevented her from coming back to work.

Eight days after the last communication from the LPN on the subject of her status re returning to work she was sent a letter of termination for violating the nursing home's 3-day no call/no show policy.

She sued for retaliation and disability discrimination.

An employee can sue for damages if the employer retaliates against the employee for exercising her rights under the workers' compensation laws.

Unless the employer can state a legitimate reason for the action taken, the court will assume it was retaliation, that is, if the employee worked for the employer before an on-the-job injury, was injured on the job, filed a claim and was then fired, demoted or disciplined.

Even if the employer can state a seemingly legitimate reason for its actions, the employee can still try to convince the court it was only a pretext for an underlying retaliatory motivation.

Violation of a "no call/no show" policy is considered a legitimate reason for discharging an employee, even one with an ongoing work comp claim.

UNITED STATES DISTRICT COURT
ILLINOIS
December 9, 2005

No Call/No Show Policy Ruled Legitimate

Since the nursing home had been honoring the LPN's medical restrictions and had been working with her on her worker's comp claim, the court could see no retaliatory motive on the part of her employer. Violation of an employer's legitimate attendance policy is grounds for terminating an employee, even one who has certain rights under the worker's comp laws. The LPN would have to show that it was not her employer's real reason in order to keep a retaliation suit alive.

No Disability Discrimination

Nurses' back injury cases give the courts the opportunity to reiterate how the Americans With Disabilities Act (ADA) is supposed to be interpreted.

To be protected from disability discrimination, a person must be a qualified individual with a disability.

The LPN was a qualified individual, qualified to work at her job and for working in general in an environment where her restrictions could be honored.

However, the courts routinely state that a lifting restriction due to a back condition or a back injury is not a disability as the concept of disability is contemplated for purposes of the ADA. A person who cannot do any significant lifting on the job does not face major restrictions to entering and remaining in the job market.

A nurse or other healthcare worker basically has no rights under the ADA solely on the basis of a lifting restriction. **Reible v. Illinois Odd Fellows Home, 2005 WL 3358869 (C.D. Ill., December 9, 2005).**

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E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
12026 15th Avenue N.E., Suite 206
Seattle, WA 98125-5049
Phone (206) 440-5860
Fax (206) 440-5862 (call before faxing)
info@nursinglaw.com
www.nursinglaw.com

Sexual Abuse Of Patients: Court Rules Skilled Nursing Facility's Investigations Were Substandard, Upholds Civil Monetary Penalty.

During a random survey inspection by the state department of health a skilled nursing facility was found to be in violation of Federal standards for the substandard manner in which the facility handled allegations of staff sexual abuse involving three residents.

The charges against the facility were upheld by the US Department of Health and Human Services Appeals Board and, in an opinion recently handed down, by the US Circuit Court of Appeals for the Sixth Circuit.

In these legal proceedings residents are referred to by numerical aliases to protect their right to confidentiality.

Resident #6

A female nurses aide witnessed a twenty year-old totally dependent quadriplegic female resident being abused in her bed in her room by a male nurses aide.

The aide right away reported it to the director of nursing who told her to write a written report of what she saw. The aide later told investigators she wrote and submitted a report. However, the report never made it into the chart. The resident was not examined by her physician and the authorities were not notified.

The aide wrote a second report five months later which did make it into the chart. An internal incident report was generated by the aide's second written report.

In response to the report there was no nursing assessment or physical examination and the incident was not reported to law enforcement. The resident was actually seen by her physician and by a pediatric gynecologist more than six months after the incident.

The court ruled the facility did an "abysmal" job of investigating the alleged incident. The female aide was quite emphatic that she witnessed the male aide abusing the resident and also insisted that she went immediately to the director of nursing with that information and submitted a written statement of what she saw.

Federal regulations require skilled nursing facilities to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. 42 CFR § 483.13 (c).

There is no doubt the facility had the required policies in place.

In cases of sexual abuse of residents by staff members:

The resident's statement should be taken.

Witnesses should be interviewed.

Evidence should be collected.

The attending physician should be notified.

The family should be notified.

Law enforcement should be notified.

Detailed reports should be issued to the state.

Unfortunately, the records show that these procedures were <u>not</u> followed in response to the allegations of abuse at issue here.

It was not an abuse of discretion for Federal inspectors to impose a $3,400 civil monetary penalty.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
December 8, 2005

The court believed the female aide did in fact twice report the incident in writing as she claimed. The facility had the obligation to collect, retain and safeguard any and all evidence pertaining to the allegations of abuse and the facility was at fault for the disappearance of the female aide's written report, in the court's judgment.

The court pointed out the facility did not notify the family – a violation of the facility's own policies – until more than a month after the abuse was reported. The physician, administrator and the family should have been contacted within one hour.

A medical examination six months after the fact was grossly inappropriate, the court went on to say.

Resident #124

This resident is a thirty-seven year-old woman diagnosed with schizophrenia and dementia. She informed the nursing staff of multiple instances of sexual abuse by one male nurses aide and at least one instance of abuse by the same aide involved in Resident #6's case.

The facility's social worker spoke with her the day she first went to the nursing staff. The social worker reported the incidents to the administrator three days later. The next day the social worker contacted the family and spoke with a sister-in-law who told the social worker the resident was known to make all sorts of allegations against African-American males wherever she went for her health care.

The resident's complaints were put to rest by the administrator with no further action beyond checking a box on a preprinted form to the effect that, "Suspect that an abuse, neglect/misappropriation incident occurred but were unable to confirm it." The physician was not notified and did not examine the resident and law enforcement was not notified.

(*Continued on next page.*)

Sexual Abuse, Substandard Investigation (Continued.)

(*Continued from previous page.*)

The court pointed out that the family was notified the same day as the resident reported the allegations of abuse, proper procedure under the circumstances. However, she was not examined by her physician and law enforcement authorities were not notified as they should have been.

Resident #141

A seventy-four year-old woman with a history of mental illness reported to a nurses aide that she had been touched inappropriately. The resident identified the man as the same aide who would be identified as involved in the other two cases. The aide reported the incident to her charge nurse and to the unit manager.

The social worker spoke with this resident later that day.

Following this incident the aide was banned from the facility and his agency and the state Department of Aging and Department of Health were notified, according to the internal incident report generated for this incident.

However, law enforcement was not notified. No nursing assessment or physical examination was performed. The physician was not contacted until more than four weeks later. He did not perform an examination, noting in the chart that an exam done untimely would not be of any value.

Complaints Discounted
Residents Had Mental Illnesses

The court soundly rejected the arguments put forth by the facility that allegations of sexual abuse made by mentally-ill patients do not have to be taken at face value. The facility argued that, "If the facility were to call the police each and every time such a person made such a mere accusation, whether because of attention-seeking behavior or simply because the resident was delusional, both police and the facility would quickly tire."

The facility claimed it should be permitted to exercise some judgment whether or not to follow through based upon the mental condition of the resident making the accusations.

The court ruled, however, that Federal regulations do not allow such so-called exercises of judgment by facility personnel in cases of claimed or suspected abuse. A facility must follow Federal standards and its own internal policies or face legal penalties, the court said.

The court conceded the facility had reason to believe that one of residents, #124, was motivated by racial prejudice and may have been trying to get herself transferred out of the facility.

However, those are merely factors to be taken into consideration and reported to the administrator, physician, family, law enforcement, state health department, etc., in the course of a proper investigation. They are not grounds to dismiss a resident's complaints out of hand.

The facility's dismissive attitude was especially troubling to the court because the same aide had been implicated in allegations involving three residents, who could not possibly have been acting in concert with one another, a fact which would have come to light immediately if all three incidents were being promptly and properly investigated. **Park v. Leavitt, 2005 WL 3334522 (6th Cir., December 8, 2005).**

Code of Federal Regulations Title 42, Part 483 Requirements for Long-Term Care Facilities

Sec. 483.13 Resident behavior and facility practices.

(a) Restraints. The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.

(b) Abuse. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

(c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

(1) The facility must--

(i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

(ii) Not employ individuals who have been--

(A) Found guilty of abusing, neglecting, or mistreating residents by a court of law; or

(B) Have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and

(iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Overdose: Unexplained Event Linked To Negligence.

The coroner's report established conclusively that the hospital patient died from a lethal dose of Oxycontin.

Two medical experts testified that the lethal dose of narcotic had to have been ingested within one hour before her death.

The night nurse had noted the patient was sleepy but arousable at 6:55 a.m. The day nurse found her blue with frothy secretions coming from her mouth at 7:25 a.m. The medication count at the 7:00 a.m. shift change had indicated none of the patient's narcotics had been checked out.

For eleven days hospital staff nurses were giving the medication which caused her death.

It is a logical inference the hospital is responsible for the overdose.

COURT OF SPECIAL APPEALS
OF MARYLAND
December 1, 2005

The Court of Special Appeals of Maryland overruled the lower court judge who had ruled in favor of the hospital.

There was no direct proof how the patient got the lethal dose of narcotic. However, the patient was exclusively under the control of hospital personnel at the time of the events in question. That element of exclusive control leads to a logical inference that some act of negligence must have been committed by the hospital, the court said.

The patient's estate's attorneys would not be required to rule out other implausible explanations like a family member providing the medication or the patient deciding to take her own life, for the lawsuit to go forward. **Tucker v. Univ. Specialty Hosp., __ A. 2d __, 2005 WL 3213897 (Md. App., December 1, 2005).**

Iodine Allergy: Court Does Not Find Nurses Negligent Who Gave Contrast Medium.

The patient suffered a severe reaction during a cerebral arteriogram. She apparently was allergic to the iodine in the contrast medium which had been injected to do the procedure.

The patient sued the clinic, her physicians and the clinic's nurses for medical negligence.

A lawsuit for medical negligence must be based on expert testimony.

The expert's opinion must state specifically what the defendant healthcare professional should have done differently.

COURT OF APPEALS OF TEXAS
October 20, 2005

The Court of Appeals of Texas threw out the case against the clinic's nurses.

It is below the legal standard of care for nurses to administer a substance containing iodine to a patient known to have an iodine allergy.

However, it was not documented in the chart and the patient could offer no proof the nurses knew or had any way of knowing she had an iodine allergy.

Furthermore, the medical records showed the allergic reaction did not occur while the contrast medium was being given. A nurse must monitor a patient for signs of an allergic reaction while a medication is being infused, the court said, but in this case it occurred after the infusion was complete. **Leday v. Zatorski, 2005 WL 2669521 (Tex. App., October 20, 2005).**

Telephone Consults: Not A Licensed Nurse, Court Finds Negligence.

The parents took their six month-old child to an after-hours medical clinic because he was vomiting and had a fever of 103.6ºF. The pediatrician's diagnosis was a stomach virus.

The next day, a Sunday, the mother called her own pediatrician's office. The pediatrician's phone was answered by a person who had graduated from a nursing school overseas but had three times failed the state nursing boards and was not licensed as a nurse. The mother told of the vomiting and high fever and the diagnosis of a stomach virus the previous day.

The non-licensed nurse told the mother to mix soda pop with Pedialyte and feed the child bananas, rice, applesauce and toast.

Two days later the parents took the child to an emergency room where bacterial meningitis was diagnosed.

It is negligent to allow a person who is not licensed as a nurse to answer phone calls from patients and to dispense medical advice without consulting with a physician.

COURT OF APPEALS OF GEORGIA
October 24, 2005

There were multiple allegations of negligence in the lawsuit. The Court of Appeals of Georgia said, among other things, that it is negligent to allow a non-licensed person to dispense medical advice over the phone.

A non-licensed person at most can only act as a go-between, relaying messages to and from the physician. **Snider v. Basilio, __ S.E. 2d __, 2005 WL 2715854 (Ga. App., October 24, 2005).**

Long-Term Care Insurance: Federal Court Wrestles With The Definition Of A Nursing Home, Denies Benefits To Policyholder Residing In Personal Care Home.

An individual purchased a Long Term Care Insurance Nursing Home Indemnity Policy from a major insurance company in 1989. In 2001 he began residing in a facility licensed by the state as a residential care home.

After the insurance company denied his claim for benefits under his long-term care insurance policy, he sued in Federal court.

The Federal District Court upheld his claim and entered judgment against the insurance company.

However, in a very recent opinion, the US Circuit Court of Appeals for the Tenth Circuit overruled the Federal District Court and denied his claim.

The gist of Tenth Circuit Court's decision is that a residential care home is not a nursing home, when it comes to deciding what the phrase "nursing home" means in a long-term care insurance policy.

Language of the Insurance Policy

A lawsuit for insurance benefits is a lawsuit for breach of contract. The contract is the insurance policy itself. The language of the contract itself is the focal point for the court in analyzing whether it will rule in favor of one side or the other in a breach of contract case.

A suit for insurance benefits is a suit for breach of contract. The contract is the insurance policy.

The court must determine what the parties to the contract intended the contract to mean and must not rewrite the contract to mean what the court thinks it ought to have meant.

The insurance contract was meant to pay a daily benefit for the beneficiary's stay in a nursing home.

State law does not define the term "nursing home."

However, the state licenses nursing facilities and personal care homes.

A nursing facility, licensed as such by the state, is what the insurance contract contemplated as the care setting for which a beneficiary's stay would qualify for the policy's daily nursing home insurance benefit.

A personal care home, licensed as such by the state, is not a nursing facility and does not qualify as a "nursing home" under the language of the long-term care insurance contract.

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT
December 12, 2005

The insurance policy defined a nursing home as:

A facility or distinctly separate part of a hospital or other institution which is licensed by the appropriate licensing agency to engage primarily in providing nursing care and related services to inpatients and:

Provides 24 hour a day nursing service under a planned program of policies and procedures which was developed with the advice of, and is periodically reviewed and executed by, a professional group of at least one physician and one Nurse; and

Has a Doctor available ... in case of emergency; and

Has at least one Nurse who is employed there full time ...; and

Has a Nurse on duty or on call at all times; and

Maintains clinical records for all patients; and

Has appropriate methods and procedures for handling and administering drugs and biologicals.

NOTE: The above requirements are typically met by licensed skilled nursing facilities, comprehensive nursing care facilities and intermediate nursing care facilities as well as some specialized wards, wings and units of hospitals. Those requirements are generally NOT met by: rest homes; homes for the aged; sheltered living accommodations; residence homes; or similar living arrangements.

The court saw it as the intent of the insurance policy to rule out payment for stay in a personal care home or assisted living facility.

The court editorialized that a hospital is also not a "nursing home," as hospitals provide care for persons with higher acuity levels than patients in nursing homes. **Gillogly v. General Electric Capital Assurance Co., __ F. 3d __, 2005 WL 3367053 (10th Cir., December 12, 2005).**

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LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

MRI / Claustrophobic Reaction: Court Upholds Patient's Right To Sue, But Rules It Is A Professional Malpractice Case.

According to the Court of Appeals of Texas, the patient suffered from claustrophobia and only consented to undergo an MRI procedure because his caregivers reassured him that he would be fully sedated and would be promptly retrieved from the MRI machine in the unlikely event he experienced any anxiety.

After being given three doses of a sedative, and over his protests that he felt neither relaxed nor tranquil, the patient was placed in the MRI machine. That, according to the court, proved to be a struggle due to the patient's large body frame.

The patient claimed his caregivers more or less shoved him into the machine as if he were a load of laundry, over his protests and against his insistence they either free him from the machine or administer still more sedation.

A towel was placed over his face and he was left in the machine for more that forty-five minutes leading to pain and numbness in many parts of his body.

Nevertheless, after describing in detail how badly the patient was mistreated, the court dismissed his lawsuit.

His lawyers had styled the court papers in the case as a consumer-protection lawsuit based on alleged unfair trade practices involving the reassurances that were given to the patient, as opposed to what actually transpired.

However, the court reasoned that the case was fundamentally a healthcare malpractice lawsuit. As such, it would be necessary for the patient to come forward with expert testimony defining the standard of care for assessing a patient's susceptibility to a claustrophobic anxiety reaction, for minimizing the probability of such a reaction, for monitoring the patient during the procedure and for deciding to go ahead or to abort the procedure in progress, all in light of how important to the procedure happened to be to the patient's diagnosis and treatment. **De La Vergne v. Methodist Healthcare System, 2005 WL 3340250 (Tex. App., December 7, 2005).**

Alcohol Abuse Suspected On The Job: Hospital's Policy To Require Screening Upheld By Court.

A nursing assistant reported for work smelling of alcohol. His nurse manager sent him for an evaluation by a nurse practitioner in the employee health office. The nurse practitioner suspected he was impaired and asked the medical director to see him and confirm her suspicions.

The nursing assistant called his union rep who advised him to refuse any further testing. For his refusal the nursing assistant was terminated. The unemployment judge ruled he was terminated for cause and the Commonwealth Court of Pennsylvania agreed.

To require an employee to choose whether to be tested or to be fired the employer must already have a policy in place for suspected intoxication on the job. The employer's established policy must be communicated to all employees so they will be aware of the consequences, which may include termination, if they are justifiably suspected of intoxication and refuse to be screened. Such a policy could be in the collective bargaining agreement with the union.

If the employer already has a policy in place and the employee has been made aware it, an employee who smells of alcohol or who acts intoxicated can be sent for testing.

An employee cannot be forced to be tested for alcohol, but can be terminated for cause if there is valid suspicion of intoxication and the employee refuses to be tested.

COMMONWEALTH COURT
OF PENNSYLVANIA
December 8, 2005

This employee's job history included a prior incident of intoxication on the job. He had signed a written agreement stipulating that just one more violation of the employer's policies could result in termination.

Smelling of alcohol on the job is employee misconduct, the court ruled, whether or not it was consumed on the premises and whether or not the employee can still fulfill his duties. **Brannigan v. Unemployment Board, __ A. 2d __, 2005 WL 3310251 (Pa. Cmwlth., December 8, 2005).**