LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

January 2007 Volume 15 Number 1

Medication Ordered Is Contraindicated: Court Discusses Nurse's Legal Responsibilities.

The patient was admitted to the hospital for treatment of his rheumatoid arthritis. He was also experiencing renal failure and was undergoing hemodialysis.

To treat his rheumatoid arthritis his physicians ordered methotrexate, a medication which is contraindicated for use with patients in renal failure.

The patient died from lymphoma related to immunosuppression related to methotrexate toxicity. It was not until the lymphoma appeared that his physicians realized the methotrexate was causing a problem.

Medication Contraindicated
Nursing Negligence

Above and beyond the negligence of the deceased's treating physicians, the widow's lawsuit alleged negligence by the hospital's nurses who followed the physicians' orders and gave the methotrexate even though it is contraindicated for a patient in renal failure.

The Appellate Court of Illinois ruled the county circuit court judge was in error to dismiss the widow's lawsuit against the hospital itself.

The Appellate Court endorsed the testimony of a registered nurse who, although not involved hands-on in this patient's care, was the care coordinator for the unit where he died.

The physicians were not hospital employees, although the consent forms the hospital knew they were using could have confused patients into thinking they were.

Nevertheless, the hospital is responsible for the negligence of its nurses who carried out the physicians' orders by giving a medication clearly contraindicated for this patient.

APPELLATE COURT OF ILLINOIS
December 12, 2006

Giving medication to patients is the legal responsibility of the nurse assigned to the patient. A nurse who actually administers a drug is required to know the reason for giving it, the drug's risks and side effects and whether it is contraindicated for a particular individual patient.

Resources available to nurses include the Physician's Desk Reference and online subscription-based information services.

The patient care coordinator testified that if a nurse received an order for a drug the nurse found to be contraindicated for the patient's medical condition she would tell the nurse to hold the drug and she would discuss the issue with the pharmacist or the physician, or have the patient's nurse do that.

It that did not resolve the issue she would go to the nursing administrator and/or the clinical director with the problem and leave it to the higher-ups in the nursing and medical chain of command to resolve the problem.

A second nurse, brought in as a outside expert, agreed that it was below the standard of care for a nurse to give a medication that is contraindicated based on the online medication database printout the nurse should have reviewed per hospital policy. **Schroeder v. Northwest Community Hosp., __ N.E. 2d __, 2006 WL 3615559 (Ill. App., December 12, 2006).**

Inside this month's issue ...

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New Subscriptions
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EMTALA: Court Interprets US Regulations Re Timing Of Triage, Insurance-Status Inquiries.

The patient's wife brought him to the hospital's emergency department.

Once he was seated in the waiting area she approached the registration clerk's desk and told the clerk her husband was vomiting blood, having difficulty breathing, having lower stomach pain and was possibly having a heart attack.

It took twenty minutes for the registration clerk to finish with the people who had arrived just ahead of them. During this time the patient himself got up and walked in and out of the hospital twice.

When it was his turn he walked up and sat in the chair in front of the registration desk. Before he could say anything he collapsed. A code was called, but after two hours of medical intervention he died.

The widow sued the hospital for violation of the US Emergency Medical Treatment and Active Labor Act (EMTALA) and for common-law negligence.

EMTALA Regulations Re Inquiry Into Insurance Status

The EMTALA was passed by Congress to prevent private hospitals from "dumping" uninsured and/or indigent patients who present themselves in the emergency department.

The broad scope of the EMTALA is to require hospitals to attend to every patient the same who presents in the emergency department with the same history, signs and symptoms.

Further, hospitals are required to create in advance standard emergency-department procedures for handling particular histories, signs and symptoms based on the hospital's available abilities and resources. Having done that, the hospital must follow its own procedures.

The essence of an EMTALA violation, the court pointed out, is a hospital's failure to follow its own standard procedures for uniform care in the emergency department. This hospital's set procedure was for a triage nurse to determine the patient's level of need prior to any inquiry regarding the individual's method of payment or insurance status.

It is said as a general rule that triage must be offered to an emergency-room patient before inquiry is made about the patient's insurance status, if the hospital is to comply with the Emergency Medical Treatment and Active Labor Act.

That is an oversimplification.

A hospital may adhere to its patient-registration procedures as long as they do not conflict with the goals of the EMTALA, the "Patient Anti-Dumping Statute."

The point is that the hospital's registration processes, including insurance inquiries, for persons presenting in the emergency room, are all right as long as they do not discourage individuals from remaining for evaluation or delay triage, initial screening or necessary stabilizing medical treatment.

Even if there is no EMTALA violation hospital personnel can still be found negligent under state common-law standards.

Hospital staff must appreciate the gravity of a patient's signs and symptoms and the need for immediate medical attention.

UNITED STATES DISTRICT COURT
KANSAS
December 1, 2006

The court pointed out that it was the patient himself who approached the registration desk to provide his information rather than being asked to do so by hospital personnel.

Federal EMTALA regulations were expressly reformulated to address this situation. The regulations now say:

(4) Delay in examination or treatment.

(i) A ... hospital may not delay providing an appropriate medical screening examination ... in order to inquire about the individual's method of payment or insurance status ... [However,]

(iv) Hospitals may follow reasonable registration processes for individuals for whom examination or treatment is required by [the EMTALA], *including asking whether an individual is insured, and, if so, what that insurance is, as long as the inquiry does not delay screening or treatment. Reasonable registration processes may not unduly discourage individuals from remaining for further evaluation.*

Although there was critical delay in providing initial triage, the delay was not attributable to the hospital requiring financial verification before offering treatment.

Negligence Allegations Remain Alive

Having thrown out the widow's allegations under the EMTALA, the court expressly ruled the widow could still pursue a wrongful death malpractice suit under state, as opposed to Federal, common-law principles of negligence. That is, it was questionable at best why this patient was not seen immediately, ahead of the apparently non-emergent patients who were next in line to see the registration clerk.

The EMTALA was not intended to create Federal malpractice standards for US hospital emergency departments. Even when there has been no disparate treatment that can be traced to insurance status or lack thereof, a patient still has the right to sue for malpractice if the facts of the case point to malpractice. **Parker v. Salina Regional Health Center, Inc., __ F. Supp. 2d __, 2006 WL 3488785 (D. Kan., December 1, 2006).**

EMTALA: E.R. Patient Admitted To ICU, Treated, Released AMA, Court Sees No Violation.

The patient was assessed in the emergency room to have taken an overdose of benzodiazepines.

He was admitted to the hospital's ICU for treatment. He came to believe hospital ICU staff were becoming angry with his psychotic conduct and were treating him differently than other patients. The next day he signed himself out of the hospital against medical advice.

The patient sued for violation of the Emergency Medical Treatment and Active Labor Act (EMTALA), claiming he was still in need of psychiatric care when he was allegedly transferred from the hospital. That is, his propensity to irrational conduct caused him to assault a police officer and receive a twenty-two month prison term.

The US Circuit Court of Appeals for the Eleventh Circuit ruled there was no violation of the EMTALA.

The patient's allegations based on his lay opinion that he should have received a "charcoal test" and that that would have made a difference carried little weight in the face of overwhelming evidence that the hospital treated him the same as it would have treated any other overdose victim and that he was given all the care he needed.

First, having admitted the patient for inpatient care is a complete defense to an EMTALA civil lawsuit.

Second, this patient received the same medical screening and stabilizing care any similar patient would have received.

He was evaluated by the emergency-room physician.

He was admitted to the ICU for continuous 1:1 nursing monitoring of cardiac tracings, blood pressure, O_2 sat and respiration and got IV fluids, lab work, urinalysis, culture and tox screen, a chest x-ray and assessment of ulcer risk.

Third, when a patient signs out against medical advice the patient is not transferred as that term is used in the EMTALA. There is no issue as to the care given prior to transfer, or the patient's condition at transfer, if the patient was not transferred.

UNITED STATES COURT OF APPEALS
ELEVENTH CIRCUIT
November 30, 2006

Hospital's Legal Obligations EMTALA

A hospital which has an emergency department must screen every individual who comes to the emergency room seeking treatment to determine whether an emergency medical condition exists.

An appropriate medical screening is the same medical screening the hospital would give to any other patient with the same presentation. The original purpose of the EMTALA was to require that indigent and uninsured patients received the same emergency care as paying patients.

Treatment must be given in the emergency room to stabilize the patient's emergency medical condition before the patient can be transferred or discharged.

However, if the patient is admitted from the emergency room to the hospital as an inpatient, the EMTALA does not consider that a transfer or discharge, so the patient does not have to be first stabilized in the emergency room.

Malpractice Issues Are Separate From EMTALA

If the patient does not receive competent care as an inpatient, the patient may be able to sue for common-law malpractice. The EMTALA does not concern itself one way or the other with common-law malpractice issues.

In this case, although the patient did not sue for malpractice, the court commented that his lay opinions about the quality of the care he received would not have been sufficient to sustain a successful malpractice case. **Johnson v. Health Central Hosp., 2006 WL 3473741 (11th Cir., November 30, 2006).**

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Hospital Patients' Rights: New Medicare/Medicaid Regulations Take Effect January 8, 2007.

New CMS regulations for hospitals deal with medical use of restraints and use of restraints and seclusion for behavior management. Other aspects of patients' rights are also affected.

The full 52-page text is available on our website at http://www.nursinglaw.com/patientrights.pdf.

FEDERAL REGISTER December 8, 2006
Pages 71378 – 71428

PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS

Sec. 482.13 Condition of participation. Patients' rights. A hospital must protect and promote each patient's rights.

****

(e) Standard: Restraint or seclusion.

All patients have the right to be free from physical or mental abuse, and corporal punishment.

All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.

(1) Definitions.

(i) A restraint is --

(A) Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely; or

(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

(C) A restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort).

(ii) Seclusion is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving. Seclusion may only be used for the management of violent or self-destructive behavior.

(2) Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm.

(3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.

(4) The use of restraint or seclusion must be--

(i) In accordance with a written modification to the patient's plan of care; and

(ii) Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospital policy in accordance with State law.

(5) The use of restraint or seclusion must be in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under Sec. 482.12 (c) and authorized to order restraint or seclusion by hospital policy in accordance with State law.

(6) Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).

(7) The attending physician must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.

(8) Unless superseded by State law that is more restrictive--

(i) Each order for restraint or seclusion used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a staff member, or others may only be renewed in accordance with the following limits for up to a total of 24 hours:

(A) 4 hours for adults 18 years of age or older;

(B) 2 hours for children and adolescents 9 to 17 years of age; or

(C) 1 hour for children under 9 years of age; and

(ii) After 24 hours, before writing a new order for the use of restraint or seclusion for the management of violent or self-destructive behavior, a physician or other licensed independent practitioner who is responsible for the care of the patient as specified under Sec. 482.12(c) of this part and authorized to order restraint or seclusion by hospital policy in accordance with State law must see and assess the patient.

(iii) Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospital policy.

(9) Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.

(10) The condition of the patient who is restrained or secluded must be monitored by a physician, other licensed independent practitioner or trained staff that have completed the training criteria specified in paragraph (f) of this section at an interval determined by hospital policy.

(11) Physician and other licensed independent practitioner training requirements must be specified in hospital policy. At a minimum, physicians and other licensed independent practitioners authorized to order restraint or seclusion by hospital policy in accordance with State law must have a working knowledge of hospital policy regarding the use of restraint or seclusion.

(12) When restraint or seclusion is used for the management of violent or self-destructive behavior that jeopardizes the immediate physical safety of the patient, a

CMS: Hospital Patients' Rights (Continued.)

staff member, or others, the patient must be seen face-to-face within 1 hour after the initiation of the intervention--

(i) By a-- (A) Physician or other licensed independent practitioner; or

(B) Registered nurse or physician assistant who has been trained in accordance with the requirements specified in paragraph (f) of this section.

(ii) To evaluate--

(A) The patient's immediate situation;

(B) The patient's reaction to the intervention;

(C) The patient's medical and behavioral condition; and

(D) The need to continue or terminate the restraint or seclusion.

(13) States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (e)(12)(i) of this section.

(14) If the face-to-face evaluation specified in paragraph (e)(12) of this section is conducted by a trained registered nurse or physician assistant, the trained registered nurse or physician assistant must consult the attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under Sec. 482.12(c) as soon as possible after the completion of the 1-hour face-to-face evaluation.

(15) All requirements specified under this paragraph are applicable to the simultaneous use of restraint and seclusion. Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored--

(i) Face-to-face by an assigned, trained staff member; or

(ii) By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

(16) When restraint or seclusion is used, there must be documentation in the patient's medical record of the following:

(i) The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;

(ii) A description of the patient's behavior and the intervention used;

(iii) Alternatives or other less restrictive interventions attempted (as applicable);

(iv) The patient's condition or symptom (s) that warranted the use of the restraint or seclusion; and

(v) The patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

(f) Standard: Restraint or seclusion: Staff training requirements.

The patient has the right to safe implementation of restraint or seclusion by trained staff.

(1) Training intervals. Staff must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion--

(i) Before performing any of the actions specified in this paragraph;

(ii) As part of orientation; and

(iii) Subsequently on a periodic basis consistent with hospital policy.

(2) Training content. The hospital must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:

(i) Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.

(ii) The use of nonphysical intervention skills.

(iii) Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.

(iv) The safe application and use of all types of restraint or seclusion used in the hospital, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia);

(v) Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.

(vi) Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospital policy associated with the 1-hour face-to-face evaluation.

(vii) The use of first aid techniques and certification in the use of cardiopulmonary resuscitation, including required periodic recertification.

(3) Trainer requirements. Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.

(4) Training documentation. The hospital must document in the staff personnel records that the training and demonstration of competency were successfully completed.

(g) Standard: Death reporting requirements:

Hospitals must report deaths associated with the use of seclusion or restraint.

(1) The hospital must report the following information to CMS:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

(2) Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.

(3) Staff must document in the patient's medical record the date and time the death was reported to CMS.

FEDERAL REGISTER December 8, 2006
Pages 71378 – 71428

Authentication Of Verbal Orders: New CMS Regulations Take Effect January 26, 2007.

New CMS regulations for hospitals deal with authentication of verbal orders and other aspects of charting in hospitals. CMS has placed the new regulations in the section dealing with hospital nursing services.

The full 25-page text is available on our website at http://www.nursinglaw.com/verbalorders.pdf.

FEDERAL REGISTER November 27, 2006
Pages 68672 – 68695

PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS

Sec. 482.23 Condition of participation: Nursing services.

* * * * *

(c) Standard: Preparation and administration of drugs. Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under Sec. 482.12(c), and accepted standards of practice.

* * * * *

(2) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law, and who is responsible for the care of the patient as specified under Sec. 482.12(c).

(i) If verbal orders are used, they are to be used infrequently.

(ii) When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedures consistent with Federal and State law.

Sec. 482.24 Condition of participation: Medical record services.

* * * * *

(c) Standard: Content of record. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services.

(1) All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures.

(i) All orders, including verbal orders, must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in paragraph (c)(1)(ii) of this section.

(ii) For the 5 year period following January 26, 2007, all orders, including verbal orders, must be dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient as specified under Sec. 482.12(c) and authorized to write orders by hospital policy in accordance with State law.

(iii) All verbal orders must be authenticated based upon Federal and State law. If there is no State law that designates a specific timeframe for the authentication of verbal orders, verbal orders must be authenticated within 48 hours.

(2) All records must document the following, as appropriate:

(i) Evidence of--

(A) A medical history and physical examination completed no more than 30 days before or 24 hours after admission. The medical history and physical examination must be placed in the patient's medical record within 24 hours after admission.

(B) An updated medical record entry documenting an examination for any changes in the patient's condition when the medical history and physical examination are completed within 30 days before admission. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission.

FEDERAL REGISTER November 27, 2006
Pages 68672 – 68695

Hospital Discharge Appeal Rights: New CMS Regulations.

On November 27, 2006 the US Centers for Medicare and Medicaid Services (CMS) announced very complex regulations dealing with hospitals' obligation to provide notification to Medicare and Medicare Advantage beneficiaries of their hospital discharge rights and rights of appeal, effective July 1, 2007.

We have placed the full text of the CMS announcement on our website at http://www.nursinglaw.com/discharge.pdf.

The format used by CMS in its Federal Register announcements is to place its comments at the beginning and the new regulations themselves at the very end.

The new regulations begin on Federal Register page 68720, in the right-hand column.

FEDERAL REGISTER November 27, 2006
Pages 68708 – 68725

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Diabetes: No Insulin Given, Court Finds Negligence.

The elderly diabetic Alzheimer's patient was completely dependent upon the nursing home's nursing staff to monitor his blood sugar and to administer appropriate doses of insulin per the sliding scale established by his physician.

As his blood-sugar was rising steadily to 540 over a seven-day period a nurse was leaving phone messages for the physician, but no insulin was given. The patient became unresponsive, was taken to the hospital in a coma and died nine days later.

The patient's family does not have to have expert testimony if the patient's caregivers themselves admit their own conduct fell below the standard of care.

The director of nursing testified not giving insulin per the physician's standing orders is below the nursing standard of care.

MISSOURI COURT OF APPEALS
November 21, 2006

The Missouri Court of Appeals approved a jury's verdict for the family against the nursing home and the nurse.

According to the court, when a physician has implemented a sliding scale for a patient's insulin, the nurse should go ahead and administer the appropriate insulin dosage and the nurse should not delay while attempting to contact the physician to report the patient's recent blood sugar readings and obtain instructions from the physician what to do. **Rush v. Senior Citizen's Nursing Home District of Ray County, __ S.W. 3d __, 2006 WL 3361856 (Mo. App., November 21, 2006).**

Chemical Dependency: Court Defines Nurse's Employer's Duty Of Reasonable Accommodation.

Does this nurse have a disability?

Being a successfully rehabilitated substance abuser fits the legal definition of being disabled.

The nurse had a history of substance abuse. She was in a monitoring program with the state board.

After her addiction had been in remission for a time she drank socially and diverted some Vicodin.

At that point it was not relevant whether the nurse was at one time successfully rehabilitated.

Once someone resumes actively abusing drugs or alcohol, the ADA regulations say the person no longer fits the definition of disabled.

Does the hospital have to provide reasonable accommodation?

In her particular clinical setting the hospital was not able to monitor her access and use of narcotics other than by placing her under continuous observation by a second nurse.

Continuous observation would not be a reasonable accommodation.

UNITED STATES DISTRICT COURT
MINNESOTA
November 30, 2006

The courts often look at disability discrimination cases from more than one angle to reach the result that is deemed appropriate. A recent case from the US District Court for the District of Minnesota, involving a chemically dependent hospital staff nurse, is a good example.

The nurse had a history of substance abuse and was being monitored by the state board. She was caught again diverting narcotics and admitted to drinking alcohol socially. She was fired.

She was hired at a second hospital without revealing her drug-use history or the fact she was in a monitoring program. When it came to light, the hospital decided it did not have the resources to provide the supervision she required to maintain staff-nurse employment and fired her.

She sued the second hospital for disability discrimination. The court dismissed her case.

Chemical Dependency
Reasonable Accommodation

First of all, with recent substance abuse this nurse would not be considered a disabled person.

Second, even if a nurse whose problem is presently in remission is deemed to be a successfully rehabilitated substance abuser, that is, a disabled person, it is still an open question in each case whether the employer can monitor the nurse.

The court noted that a healthcare employer is not necessarily obligated, under the rubric of reasonable accommodation, to provide the monitoring that an employee with a drug or alcohol history needs in order to retain his or her license or to practice without undue risk of diversion.

In this case the second hospital believed the neonatal intensive care unit was an ideal environment for diverting narcotics, that is, it was not safe not to have constant one-on-one observation by another nurse, and that sort of accommodation would be unreasonable for the employer. **Dovenmuehler v. St. Could Hosp., 2006 WL 3463394 (D. Minn., November 30, 2006).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Arbitration: Surrogate Cannot Sign For Patient.

The son of the eighty-six year-old patient had handled her business affairs for some years before he admitted her to a nursing home.

The admission nursing assessment indicated the patient's memory and cognitive abilities were seriously impaired. The son signed the admission papers for her as the responsible party. The admission papers included an agreement to go to arbitration, rather than file a civil lawsuit in court, if a liability claim arose against the nursing home.

The Court of Appeals of Mississippi ruled the son did not have to go to arbitration against the nursing over the circumstances of his mother's death but would have his day in court.

The law sets out a list of decisions a surrogate decision-maker can make for the healthcare of an impaired patient. The list does not include consenting to arbitration on the patient's behalf. **Covenant Health & Rehab. v. Estate of Lambert, __ So. 2d __, 2006 WL 3593437 (Miss. App., December 12, 2006).**

Arbitration: Surrogate Cannot Sign For Patient.

The patient was admitted to the hospital for head injuries from a fall. He was put on a ventilator. He could not speak, but he was alert and aware of his surroundings and could communicate effectively by responding to questions with hand and eye signals. The hospital admissions coordinator, speaking only in English, got his wife to sign an arbitration agreement.

A lawsuit was filed on his behalf against the hospital for negligence by hospital staff in managing his ventilator care. The hospital tried unsuccessfully to have the civil lawsuit thrown out and to force the patient into arbitration.

The Court of Appeal of California commented on the fact the wife did not understand English. The basis for the court's ruling, however, was that a family member who can make other healthcare decisions for a patient does not have inherent authority to consent to arbitration. **Del Prado v. THC Orange County, Inc., 2006 WL 3555563 (Cal. App., December 11, 2006).**

Alzheimer's: Aide Who Punished Uncooperative Patient Convicted Of Cruelty To An Infirm Person.

Two aides were trying to dress an uncooperative Alzheimer's patient. The patient struck one of the aides. The aide slapped the patient. The patient hit back and the aide slapped her again. When the other aide insisted she stop slapping the patient the aide left the room.

A week later the aide who had slapped the patient was trying to shower another uncooperative Alzheimer's patient.

The aide was seen standing by the door to an outside courtyard. She was asked where her patient was and said she was outside. When asked why, she replied her patient had been, "acting a fool." Fifteen minutes later she brought the patient back indoors slumped down in her wheelchair.

Cruelty to the infirm is intentional or criminally negligent mistreatment or neglect by any person, including a caregiver, which causes unjustifiable pain or suffering to an infirm, aged or disabled adult or a resident of a nursing home, mental facility or hospital.

Unjustifiable means the pain or suffering is not an inevitable part of necessary medical care and treatment.

COURT OF APPEAL OF LOUISIANA
December 13, 2006

The Court of Appeal of Louisiana upheld the aide's criminal conviction for simple battery of the first patient and attempted cruelty toward the second.

It was only 29° F when she put her patient outside for the sole purpose of inflicting pain or suffering upon her victim who was an infirm, aged or disabled adult resident of a nursing home entrusted to her care.

The aide's sentence of five years imprisonment at hard labor for the attempted cruelty offense was justified, the court ruled, because she abused her position, that is, she violated the trust placed in her by the victims' families who looked to her to care for their very vulnerable loved ones. **State v. Browhow, __ So. 2d __, 2006 WL 3615551 (La. App., December 13, 2006).**