LEGAL EAGLE EYE NEWSLETTER

January 2010 *For the Nursing Profession* Volume 18 Number 1

Patient Chokes, Dies: Nurse Ruled Negligent, Delegated Supervision Of Patient To Aide.

The eighty-four year-old patient was admitted to the hospital by his long-time primary care physician because he was complaining of not feeling well.

Once he was settled into his hospital room around 10:00 p.m. a nurses aide came in, left him a sandwich on his tray table and exited the room.

The patient's roommate heard the elderly man choking and used his own call button to summon a nurse.

A code was called. The patient was intubated. Remnants of a turkey sandwich were suctioned from his trachea and lungs before he died.

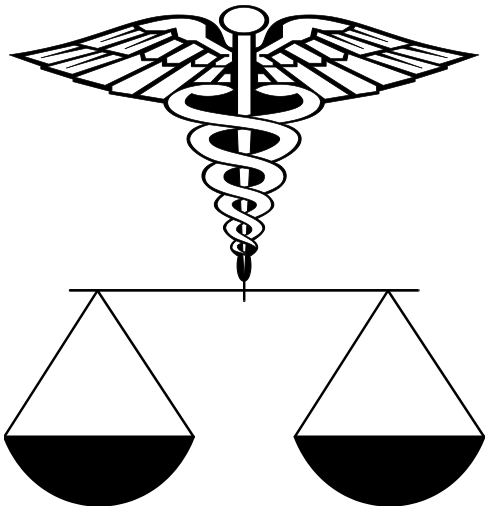
The family privately hired a pathologist to perform an autopsy. The autopsy confirmed aspiration of food as the cause of the cardiopulmonary arrest that killed the patient.

The family's lawsuit resulted in a $500,000 verdict in their favor against the hospital. The verdict was upheld by the Appellate Court of Illinois.

Nursing Standard of Care

The Court endorsed the family's nursing expert's testimony as correctly stating the nursing standard of care.

The patient's primary-care physician, who knew the patient well, alerted the nurse admitting the patient that the patient had dysphagia, a swallowing disorder, and gave instructions to watch the patient closely while he ate.



The nurse delegated the task of supervising the patient's eating to an aide without determining that the aide was qualified for that task.

Before a nurse may delegate any care task to an aide, it is the nurse's responsibility to determine that the task is appropriate for performance by an aide and by the particular aide selected to perform it.

APPELLATE COURT OF ILLINOIS
November 24, 2009

Having been so instructed by the patient's physician, the patient's nurse had a professional responsibility either to watch the patient herself as he ate or to delegate the task of supervising the patient only to a non-licensed person known by the nurse to appreciate the patient-safety risk involved if the patient was not closely supervised and also known to be able to respond in an emergency by calling for assistance and performing the Heimlich maneuver.

In general, it is a nursing responsibility to manage the care of a patient whose hands-on care is being performed by non-licensed nurses aides.

If a patient is known to have a swallowing disorder, a nurse can delegate the task of feeding the patient to an aide only after assessing the aide's level of knowledge, training and experience and only after determining that the aide is qualified to perform the task.

A nurses aide acts under the nurse's direct supervision when performing supportive care such as bathing and feeding the patient.

Violation of the standard of care for a care-giving task by a non-licensed aide is also a violation of the standard of care by the professional nurse responsible for supervising the aide. **Estate of Travaglini v. Ingalls Health, __ N.E. 2d __, 2009 WL 4432565 (Ill. App., November 24, 2009).**

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Fall: Jury Decides Patient's Nurses Were Not Negligent.

The eighty-one year-old patient had to be readmitted to the hospital for abdominal pain four weeks after sigmoid resection surgery.

At the time of this admission his nurse assessed him as only a moderate fall risk. He was alert and able to ambulate independently and had no history of having fallen before in the hospital or at home. However, he did have lower extremity weakness bilaterally, had some memory loss and wore eyeglasses.

The nurse issued him a fall bracelet. Her initial care plan included reassessment at the start of every shift of his orientation and level of independent mobility and reminders to change position slowly and to request assistance to get out of bed. The bed was to be kept in the low position, his call bell was to be kept within his reach and he was to be checked visually at least every two hours.

He got narcotics during the night for sharp abdominal pain, but by morning his physician wrote orders he was ready for physical therapy. PT got him out of bed twice that p.m. and ambulated him more than 300 feet with contact assistance. His fall risk was scaled back from 6/10 to 4/10.

Late that night he was assessed as alert and oriented with no memory deficit. He was up in his room and getting to the bathroom independently without assistance and had a steady gait. His fall risk was scaled back to 3/10. He was given Ambien for sleep and checked at two-hour intervals.

At 4:50 a.m. his roommate pushed his own call button because there was a noise in the bathroom. The patient was found on the floor, awake but unable to speak. A quick assessment showed that his right arm and leg were flaccid. The medical response team came and took him for a CT, but he was already posturing before they got it done. He died later that day from a subdural hematoma sustained in the fall.

The jury in the Court of Common Pleas, Allegheny County, Pennsylvania ruled his nursing care was completely within the standard of care and absolved his nurses from allegations of negligence.

Estate of Williams v. Sewickley Valley Hosp., 2009 WL 4275232 (Ct. Comm. Pl. Allegheny Co., Pennsylvania, October 8, 2009).

The hospital offered to pay the deceased's funeral expenses of $7,115. That amount was the sum total of the jury's award at the conclusion of the trial.

The jury did not award damages against the hospital for nursing negligence leading to the patient's death.

The family's nursing expert testified the hospital's nursing staff failed to meet the standard of care by not providing the patient with a safe environment. The bed should have been placed against the wall with a floor mat next to the bed. A bed alarm should have been installed. Visual checks should have been more frequent than every two hours.

The hospital's nursing expert, on the other hand, testified that frequent nursing assessments demonstrated that the patient was consistently alert and oriented. He was not restless or agitated. He had never tried to get out of bed without needed assistance. A fall mat or bed alarm was not warranted.

A bad outcome, in and of itself, does not prove that the patient's caregivers violated the standard of care before the fact.

COURT OF COMMON PLEAS
ALLEGHENY COUNTY, PENNSYLVANIA
October 8, 2009

Fall: Court Sees Grounds For Negligence Suit.

The patient was residing temporarily in a long-term care facility recovering from surgery.

She was found on the floor in her room at 4:00 a.m. with injuries to her eyes and face and sent to the hospital for emergency surgery.

The family sued the nursing facility for providing negligent nursing care.

There is little if any documentation how or exactly where in relation to her bed the patient was found on the floor.

There is also little or no documentation whether a nurse had attended to the patient or any other care had been provided for the patient in the hours before she was found on the floor.

COURT OF APPEALS OF TEXAS
December 9, 2009

The Court of Appeals of Texas ruled the reports prepared by the family's nursing and medical experts made out valid grounds for the lawsuit.

The nursing expert stated that fall precautions should have been implemented, that is, the bed should have been lowered, fall mats placed around the bed and a bed alarm put in place and activated.

Inadequate Nursing Documentation

The Court discounted the facility's argument that the family's nursing expert's opinion was only a generic recital of some general principles of nursing care.

The patient's treatment records were wholly inadequate as to what, if anything, was being done by way of care planning or actual care for fall risk. There was also no record of any direct contact with the patient during the hours preceding her fall, how long she was on the floor or how it was discovered that she was lying there.

Regent Care v. Craig, 2009 WL 4671323 (Tex. App., December 9, 2009).

Fall: Elderly Patient's Estate Awarded Large Verdict.

An eighty year-old woman was involved in a motor vehicle accident in which three of her ribs were cracked.

Since she weighed only sixty-four pounds her doctor decided to admit her to a nursing home where supportive care would be available not just to help her recover from her injuries but also to regain her strength overall and put on some weight.

Five hours after admission to the nursing home she fell and fractured her hip while trying to get to the restroom unassisted. She was taken to a hospital for surgery, which was not successful, and she died in the hospital's ICU.

The family's lawsuit in the Superior Court, Fairfield District Court, Connecticut resulted in a verdict of $1,453,177 after the jury discounted the damages for 5.9% for comparative negligence by the deceased.

Reportedly no treatment plan had been implemented for the patient on admission but one was created and inserted into her chart after she had already fallen in the nursing home and had died in the hospital. **Estate of Miller v. Darien Health Care, 2009 WL 4758488 (Sup. Ct. Fairfield Co., Connecticut, August 1, 2009).**

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Fall: Care Plan Was Violated.

An aide reportedly attempted to lift a patient into bed without help from a second staff person. The patient's femur was fractured in the process. The patient had to be taken to the hospital and died six days later.

The jury in the Superior Court, Buncombe County, North Carolina awarded $300,000 to the family of the deceased.

The jury verdict was based on the fact that the femur fracture was a direct result of a clear violation of the patient's care plan which called for two-person assistance in transfers. The jury did not believe the injury was caused by the paramedics who were called to transport her to the hospital. **Estate of Odom v. Aston Park Health Care, 2009 WL 4758614 (Sup. Ct. Buncombe Co., North Carolina, August 21, 2009).**

Newborn Loses Fingertip: Nurse Ruled Negligent.

The jury in the Circuit Court, Calhoun County, Alabama deliberated only two hours before returning a verdict of $125,000 for an infant who lost the tip of a pinky finger as a nurse was using her scissors to cut off his identification bracelet just prior to discharge from the nursery.

The hospital reportedly also wrote off an additional $31,309.63 in medical expenses. **Pruitt v. Jacksonville Medical Ctr., 2009 WL 4577605 (Sup. Ct. Calhoun Co., Alabama, May 7, 2009).**

Lab Results Left Out Of Chart: Hospital Settles With Family Of The Deceased.

The patient was in a skilled nursing facility for rehab after knee surgery.

With a history of blot clots in her lungs her physician had her on Coumadin with routine orders for blood work to monitor her clotting factors.

Eight days after surgery the results of blood work came back from the lab showing an unacceptably high level of a clotting factor which should have been reported to the attending physician as an indication the Coumadin dosage needed to be stepped up or other medical follow-up was needed.

The patient's nurse, however, never contacted the physician or forwarded the lab results to him.

The patient died from blood clots in her lungs two days after the lab results came back.

After the patient died her nurse reportedly went back and made sure the lab test results were in the chart and also forged a back-dated progress note to the effect that she had contacted the physician when the lab results were first forwarded to her.

The facility basically admitted there was an error and negotiated a $900,000 settlement in exchange for the family dropping their lawsuit filed in the Superior Court, Essex County, New Jersey. **Estate of Wells v. White House Healthcare, 2009 WL 4275203 (Sup. Ct. Essex Co., New Jersey, September 30, 2009).**

Heat Wave, No Air Conditioning: Dehydrated Patient Dies.

The family accepted a $300,000 settlement of their lawsuit filed in the Superior Court, Los Angeles County, California, from a long-term nursing care facility after their family member, thirty-six years old and in a persistent vegetative state following a motor vehicle accident, died from dehydration after the air conditioning failed during a four-day heat wave during which temperatures reached 106°F.

The nursing home reportedly opened up the doors and windows, but that did not reduce the temperature inside and only let insects into the building which swarmed around the helpless patient. **Confidential v. Confidential, 2009 WL 4229253 (Sup. Ct., Los Angeles Co., California, August 1, 2009).**

Decubitus Ulcers: Settlement Paid.

When the elderly patient was admitted to the hospital for a total knee replacement her nursing assessment showed no problem with her skin integrity.

When she left the hospital three weeks later she reportedly did have pressure ulcers. After only four days in a nursing home she had to be re-admitted to the hospital for several weeks to undergo multiple surgical debridement procedures for her decubitus ulcers.

At another nursing home she got specialized wound care for osteomyelitis until she died almost a year later.

The hospital and nursing home were faulted in the family's lawsuit for failing to turn and reposition her every two hours, failing to initiate pressure-relief measures, failing to provide adequate hygiene and nutritional support and failing to monitor and document changes in her condition.

The hospital and first nursing home contributed to a $120,000 settlement of the family's lawsuit filed in the Circuit Court, Wayne County, Michigan. **Estate of Butler v. Henry Ford Health System, 2009 WL 4406770 (Cir. Ct. Wayne Co., Michigan, August 14, 2009).**

Diuretic: Nursing Home Did Not Monitor, Advocate For The Patient.

The ninety-one year-old WWII veteran entered the state veteran's home weighing 172 pounds.

He was under the care of the US VA medical center clinic for congestive heart failure for which he was taking a diuretic.

His medical conditions also included atrial fibrillation, GERD, Guillian-Barre syndrome and anemia. He was taking a total of nine medications, including his diuretic.

His daughter, a nurse, after using her power of attorney to admit her father, began to see the need oversee his care.

First, it appeared to her he was getting more of the diuretic than was prescribed. Then began an overall decline in his health, the most obvious sign being a 36 pound weight loss in just two weeks accompanied by signs of dehydration.

Nursing home staff refused to listen to the daughter's pleas, except that they reportedly confirmed the pre-admission medication dosages with the US VA pharmacy and let it go at that.

Nurses Did Not Monitor Patient Did Not Advocate for the Patient After Changes in Health Status

The nursing home's nurses were faulted for failing to take action after obvious changes in the patient's health status. Extremely rapid weight loss in a patient on medication to remove fluid from the body required the nurses to advocate with a physician to take a look at the adverse effects the diuretic was having, to get lab work done to check his kidney function and his electrolytes and to consider reevaluation of the medical course of treatment.

He soon died from dehydration, renal failure and a toxic potassium level.

The judge in the District Court, Oklahoma County, Oklahoma indicated that the family was entitled to more by way of compensation, but that she was limited by the state's damage-cap law for medical malpractice only to awarding the maximum sum allowed, $175,000. **Estate of Shelton v. State of Oklahoma, 2009 WL 4828964 (Dist. Ct. Oklahoma Co., Oklahoma, September 30, 2009).**

Labor & Delivery: Nurses Did Not Advocate For The Patient.

A very complex obstetric malpractice lawsuit filed in the Supreme Court, Orange County, New York, resulted in a total settlement of $10,000,000 for a child who suffered brain injuries at birth.

The child, now eight years old, suffers from spastic quadriparesis, cannot eat or speak and has impaired vision.

Nurses Failed to Advocate For the Patient

As it relates to the hospital's labor and delivery nurses, the allegations in the lawsuit were that they should have called the obstetrician and insisted he come to the hospital during the night after their standard nursing interventions, repositioning the patient and upping the O_2, did not change the non-reassuring monitor tracings they were seeing.

If they had called the obstetrician and he did not want to come in, or if they failed to reach him, it was the nurses' duty to initiate the nursing chain of command. That is, the staff nurses should have gone to their charge nurse, who could contact the house supervisor, all the way up the ladder of authority, until a physician came in, looked at the tracings, checked on the patient and decided what to do. **Alvarez v. Sherman, 2009 WL 4731164 (Sup. Ct. Orange Co., New York, July 27, 2009).**

JCAHO: Authority Renewed By CMS.

Congress in 2008 required the Joint Commission to apply to the US Centers for Medicare and Medicaid Services (CMS) for renewal of its authority to accredit US hospitals.

After extensive modifications of its standards, on November 27, 2009 CMS recognized JCAHO as a national accreditation program for hospitals for the period July 15, 2010 through July 15, 2014.

www.nursinglaw.com/JCAHO112709.pdf

FEDERAL REGISTER November 27, 2009
Pages 62333 - 62336

Administrative Leave: Aide Not A Victim Of Racial Discrimination.

An African-American Mental Health Therapy Aide working in a state psychiatric facility was placed on paid administrative leave after a patient filed a complaint that she and two other aides assigned to the patient for close suicide watch had fallen asleep on duty.

She received a letter explaining that the reason for her leave was to facilitate the investigation of the allegations. She cooperated with the internal investigation by giving a sworn deposition in which she admitted she might have momentarily nodded off but denied sleeping on duty.

After giving her deposition she was taken off administrative leave and reassigned to the p.m. shift. Then she was restored to her night shift after the patient in question had been moved to another unit.

To be a victim of discrimination an employee must suffer adverse employment action based on race.

Being placed on paid administrative leave pending an investigation of allegations is not adverse employment action.

UNITED STATES DISTRICT COURT
NEW YORK
September 11, 2009

The US District Court for the Southern District of New York ruled she had no grounds to sue for race discrimination.

According to the Court, placing an employee on paid administrative leave, in and of itself, is not "adverse employment action," one of the necessary elements of a discrimination case.

It was not relevant to go into the issue whether the facility had a practice of placing minorities on administrative leave more readily than non-minorities in similar situations, the Court said. **Bryant v. New York State Psychiatric Inst., 2009 WL 2957778 (S.D. N.Y., September 11, 2009).**

Gender-Based Patient-Care Assignments: Male Psych Aide's Case Dismissed.

A non-licensed male caregiver employed as a Unit Treatment Rehabilitation Specialist in a state facility serving forensic and civilly-committed psychiatric patients filed a gender-discrimination lawsuit against his employer.

His lawsuit challenged the facility's practice of allowing physicians to write orders specifying staff gender for 1:1 supervision of patients who required staff to be assigned on a 1:1 basis due to their extreme propensities for acting out.

As a general rule a facility would commit discrimination against its employees by assigning caregivers to particular tasks based on the caregiver's gender.

However, this facility had legitimate grounds to allow staff physicians to write orders specifying the gender of the person to sit with a particular patient 1:1.

UNITED STATES DISTRICT COURT
FLORIDA
December 3, 2009

The US District Court for the Northern District of Florida threw out his case.

He is a male caregiver; many of his assignments were difficult patients. However, there was no proof that male staff were disproportionately given the difficult patients. Female staff were also assigned to difficult patients for whom male caregivers were seen as inappropriate.

The Court presumed that any order specifying the gender of a 1:1 sitter was written because the patient was known to act out toward staff of the other gender. The Court did not need to see the rationale explained in the order or the progress notes each time such an order was written. **Calhoun v. Florida State Hosp., 2009 WL 4728028 (N.D. Fla., December 3, 2009).**

Nurse Reassigned: Court Sees No Discrimination.

A patient on the neurosurgical ICU allegedly threatened to kill his nurse. The patient claimed the nurse slapped him, physically and verbally abused him, cursed at him, broke his laptop computer and rummaged through his personal items.

Pursuant to hospital policy the nurse was suspended without pay pending an investigation. The investigation found no basis for the patient's accusations, so the nurse was reinstated as an employee of the institution with full back-pay for the two weeks she lost.

She was told, however, she was going to be reassigned to another unit while the patient in question remained on the neurosurgical ICU. The new assignment had the same job title, hours, pay and benefits as her previous position.

The nurse never came back to work. Instead, she resigned and filed a lawsuit alleging she was discriminated against because of her race.

The nurse would have to show a pattern of non-minority nurses accused of abusing a patient being treated differently, that is, more favorably than she was treated.

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT
December 14, 2009

The US Court of Appeals for the Fifth Circuit upheld the lower Federal court's decision to dismiss her race and gender discrimination lawsuit.

The nurse admitted it is legitimate for a healthcare facility to suspend a nurse accused of abusing a patient pending an investigation.

There was no proof that non-minority nurses faced with the same allegations of abuse were treated differently that she was. She was not treated differently than non-minorities under the same circumstances. **McGarry v. Univ. of Miss. Med. Ctr., 2009 WL 4823013 (5th Cir., December 14, 2009).**

Bariatric Surgery: Nurses, Residents Monitored Patient After Surgery, Not Liable For Death.

The forty-eight year-old patient weighed 416 pounds and had gained 200 pounds in the preceding eighteen months. A highly experienced gastric bypass surgeon obtained two cardiology workups and a pulmonary workup before going ahead with a Roux-en-Y procedure.

The American Society for Bariatric and Metabolic Surgeons has very specific guidelines for monitoring the post-op patient's heart rate for signs of systemic reaction to leakage.

SUPREME COURT
NASSAU COUNTY, NEW YORK
October 9, 2009

The nurses and resident physicians monitoring him during the two days after surgery carefully observed and charted that his heart rate sometimes spiked at 165 but then returned to baseline below 120.

When foul-smelling drainage was detected at the incision site, the surgeon was promptly notified. Medical testing was done to confirm there was a leak and he was taken back to surgery. He arrested soon after the second surgery and lingered in the ICU fifty days before dying with multiple organ failure from sepsis.

The jury in the Supreme Court, Nassau County, New York cleared the patient's nurses and the resident physicians from allegations of negligence.

The hospital had expert testimony that the standard of care is defined by specific guidelines for post-bariatric-surgery care which establish when a patient's pattern of elevated heart rate is to be considered a sign that the patient's anastomosis may be leaking and testing is indicated. Those guidelines were never transgressed by this patient's caregivers. **Estate of Apikoglu v. Leitman, 2009 WL 4731193 (Sup. Ct. Nassau Co, New York, October 9, 2009).**

Emergency Room: No Negligence, Staff Not Liable For Cardiac Patient's Death.

The thirty-two year-old patient came to the E.R. stating that he had been having chest pains more than twelve hours.

He was given an EKG and seen by the E.R. physician within forty minutes of arrival. The EKG was not abnormal. When his abnormal enzyme results came back from the lab, however, another EKG was obtained which indicated that interventional cardiac treatment was needed.

The hospital did not have a cath lab capable of meeting his needs so arrangements were made to transfer him to another facility, where he died almost upon arrival.

The patient waited at home twelve hours to go to the E.R. for his chest pain.

He did not share with the E.R. personnel the full extent of his history of heart problems.

He threatened the E.R. nurse, shouted profanities and demanded to be seen sooner even though the E.R. was full of patients.

CIRCUIT COURT
WAYNE COUNTY, MICHIGAN
January 7, 2009

The jury in the Circuit Court, Wayne County, Michigan ruled the E.R. nursing and medical staff at the first hospital met the standard of care and did all they could for the patient. The case ended in a defense verdict which has not been appealed.

The first EKG did not substantiate a cardiac emergency. When there were positive indications of such an emergency from the lab results and the second EKG an appropriate transfer was arranged in a timely fashion to a medical facility with major cardiac-care capability. **Estate of O'Neal v. Neher, 2009 WL 4758625 (Cir. Ct. Wayne Co., Michigan, January 7, 2009).**

Heparin Lock: Nurse Gave Concentrated Medication IV.

The patient was prescribed Phenergan for nausea while in the hospital recovering from gynecological surgery.

The IV on the back of her left hand was converted to a Hep-Lock the day after surgery. She got the Phenergan several more days without any problem until an inexperienced nurse who had just completed her training reportedly gave Phenergan through the Hep-Lock in a more concentrated form which is not indicated for IV administration. The patient experienced an immediate burning sensation in the hand and arm.

The patient filed suit against the hospital for nursing negligence.

The nurse was negligent. However, the evidence is lacking that the nurse's negligence caused the disabling injuries the patient claimed in her lawsuit.

CIRCUIT COURT
WASHTENAW COUNTY, MICHIGAN
May 20, 2009

The patient, a dentist, claimed that damage to her anterior interosseous nerve resulted in partial loss of function in the thumb, index finger and middle finger of her left hand, which added up to a major impairment of her earning capacity in her profession.

The hospital denied that the nurse was negligent. In the alternative, even if the nurse was negligent, the hospital's attorney argued the patient's injury was at most a mild and temporary nerve irritation which did not affect her functional capacity.

The jury in the Circuit Court, Washtenaw County, Michigan ruled that the nurse committed an inexcusable medication error and was negligent, but that error did not cause the injuries the patient was claiming in her lawsuit. **Stahle v. Chelsea Community Hosp., 2009 WL 4758635 (Cir. Ct. Washtenaw Co., Michigan, May 20, 2009).**

Failure To Notify Physician: Nurses Held Partially Responsible For Patient's Death.

The patient was admitted to a hospital med/surg unit during the early a.m. hours after being brought to the E.R. by ambulance for severe abdominal pain.

Her medical history included bariatric surgery, cesarean delivery of twins and gallbladder removal.

That afternoon an internist wrote an order for a surgical consult. The patient's nurse spoke with a surgeon who agreed he would accept the consult. He did not intend to come in to see the patient until the next a.m., and he told the nurse to have him contacted if the patient's condition became unstable before then.

During the night the patient had to be transferred to the ICU, but neither the nurses or the residents on duty notified the surgeon of that development.

The patient's mother called the surgeon at 7:00 a.m. The patient arrested at 8:45 a.m. A laparoscopy was done on the comatose patient at 11:45 a.m. for a bowel herniation. The patient never awoke from coma and died twenty-one months later.

A patient with a history of multiple abdominal surgeries is at risk for bowel herniation and ischemia, which can require prompt surgical intervention.

CIRCUIT COURT
MIAMI-DADE COUNTY, FLORIDA
October 30, 2009

The jury in the Circuit Court, Miami-Dade County, Florida awarded a verdict which placed 15% of the liability for the patient's death on the hospital's nurses for failing to notify the surgeon of the change in the patient's status during the night.

Most of the blame went to the physicians for failing to go forward sooner with the surgical consult and the laparoscopy. **Estate of Brown v. Martinez, 2009 WL 4808541 (Cir. Ct. Miami-Dade Co., Florida, October 30, 2009).**

Antibiotic: Nursing Home Contributes To Settlement For Adverse Reaction.

The eighty-seven year-old nursing home resident was prescribed Bactrim by his personal physician to treat a urinary tract infection.

The patient had an allergic reaction to the medication, eventually diagnosed as Stevens-Johnson Syndrome, a form of toxic epidermal necrolysis, which caused second– and third-degree burns over 17% of his body.

One recognized cause of that disorder is an idiopathic reaction to medication. Treatment starts, once the condition is recognized, with immediate cessation of the medication causing the adverse reaction.

Allocation of fault in the settlement of the lawsuit filed in the Court of Common Pleas, Allegheny County, Pennsylvania was apportioned 65% to the nursing home and 35% to the patient's physician.

The nursing home allegedly failed to notify the physician of a possible allergic reaction to a medication known to cause allergic reactions, specifically Stevens-Johnson Syndrome, when the patient started complaining of burning and itching sensations in his skin. **Lee v. Health Care & Retirement Corp., 2009 WL 4878254 (Ct. Comm. Pl. Allegheny Co., Pennsylvania, March 1, 2009).**

Off-Label Use: Nurse Implicated For Lack Of Informed Consent.

The patient sued over alleged complications following a cervical diskectomy in which there was off-label use by the surgeon of bone morphogenic protein.

The US District Court for the District of South Dakota ruled that both the physician and the nurse who participated in the patient's pre-surgery consult had a duty to inform her that off-label use of that compound was being contemplated. **DeNeui v. Wellman, 2009 WL 4847086 (D.S.D., December 9, 2009).**

Patient Suicide: Court Finds No Negligence.

The patient, who was under the VA hospital's ongoing care for chronic pain, came to the same VA hospital's emergency room after he overdosed on his pain medication. He was kept in the emergency room overnight.

The next day a psychiatry resident decided to go forward with an involuntary mental health hold and ordered suicide precautions. A nurse sat with the patient 1:1 until later that afternoon when the staff psychiatrist decided that 1:1 supervision was not necessary and downgraded the patient's suicide precautions to visual checks every fifteen minutes.

The nursing progress notes documented fifteen-minute checks by the nursing staff until shortly after midnight when the patient's nurse found he had hanged himself in his room.

The US Court of Appeals for the Eleventh Circuit agreed with the decision of the lower Federal court to dismiss the case, based on the testimony of the doctors and nurses who cared for the patient that their assessments were appropriate. **Ortiz v. US, 2009 WL 4194849 (11th Cir., November 30,2009).**

Physician's Staff Privileges: Court OK's Suspension, Bullied Nurses.

The Appellate Court of Illinois ruled that a hospital was within its rights to suspend a surgeon's staff privileges for unprofessional conduct, i.e., for creating a hostile environment by yelling at and bullying the nurses in the surgical department.

He reportedly yelled because an item was not stocked in the O.R. as it should have been, called a nurse incompetent who erred dislodging a specimen clip and yelled at another nurse when an item ordered by the anesthesiologist was still being sterilized and the case could not start. **Dookeran v. County of Cook, __ N.E. 2d __, 2009 WL 4827852 (Ill. App., December 14, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Narcotics Diversion: No *Miranda* Warning Before Interview, Nurse's Indictment Upheld.

An LPN was contacted by an investigator for the Board of Nursing. He said he wanted to speak with her about a complaint that had been filed with the Board for narcotics diversion, that is, felony thefts of controlled substances.

The LPN agreed to meet him at the local public library. When the investigator arrived at the public library for the meeting he had an investigator from the Board of Pharmacy with him.

The three met in a small room with glass walls on three sides. The door was closed but not locked. The LPN sat on the side of the table closest to the door.

At the start of the one-hour meeting the two men told the LPN that criminal charges were probably going to be filed against her, but that they would recommend leniency in sentencing if she was willing to cooperate and give them the information they wanted.

After meeting with the LPN the two investigators contacted a detective in the local county sheriff's office and reported what she had had to say.

The LPN was indicted by the local grand jury on felony charges.

At no time during the interview at the library was the LPN given a *Miranda* warning, that is, *"You have the right to remain silent. Anything you say can and will be used against you in a court of law. You have the right to have an attorney present during questioning and if you cannot afford one an attorney will be provided to represent you. Do you understand these rights? Are you willing to waive your right to remain silent and answer questions?"*

The Court of Appeals of Ohio overruled the LPN's challenge to the indictment based on the fact she was given no *Miranda* warning before she made statements incriminating herself.

She did have the right to remain silent. However, the investigators had no duty to read her a *Miranda* warning advising her of that right because she was not in law enforcement custody. She came in voluntarily and could have just turned around and exited, the Court said.

Threatening prosecution or making promises did not change the fact she was not in custody and was not entitled to a *Miranda* warning before she voluntarily answered their questions. **State v. Gradisher, 2009 WL 4647378 (Ohio App., December 9, 2009).**

Domestic Violence: Hospital Has No Legal Duty To Keep Victim From Abuser, Lawsuit Dismissed.

A young woman and her husband arrived at the hospital's E.R. seeking treatment for lacerations on the woman's hand and thigh.

They said she had just been thrown from a horse, but the jeans she had on were not torn. The husband refused to leave her side and the woman was sketchy about the details. The nurse suspected domestic abuse.

When the husband was not looking the nurse pointed to a domestic-abuse poster on the wall. The woman shook her head vigorously to say, "No."

When they finally examined the thigh laceration it appeared to need surgery. When the patient was in recovery her mother came in. She said she did not believe the story about the horse; the husband had assaulted her daughter. She was told to call the police.

The hospital's nurses gave the victim the chance to admit what really happened, offered her referrals to outside resources, provided an opportunity to contact law enforcement and suggested she did not need to leave the hospital with him.

The hospital had no legal authority or responsibility to keep the victim from leaving the hospital with her abuser and is not liable for what happened later.

SUPREME COURT OF INDIANA
November 30, 2009

Two hospital security guards cornered the husband and searched him for weapons. While that was going on a nurse got with the patient and told her she did not have to leave with him.

The patient just insisted her prescription be changed from Darvocet to OxyContin and left with her husband

A few blocks from the hospital the husband shot and killed her with a gun the security guards did not find.

The Supreme Court of Indiana dismissed the lawsuit the woman's family filed against the hospital.

The hospital's nursing and security staff did everything they reasonably could have under the circumstances. Ill advised as it was, the patient's decision to leave with her abuser came within the parameters of patient autonomy. **McSwane v. Bloomington Hosp., 916 N.E. 2d 906 (Ind., November 30, 2009).**