# LEGAL EAGLE EYE NEWSLETTER

January 2012 — *For the Nursing Profession* — Volume 20 Number 1


# Preeclampsia: Nurse Failed To Monitor High-Risk Patient After Cesarean, Ruled Negligent.

The patient was admitted to the hospital's labor and delivery unit for the birth of her fourth child. She had a history of pregnancy-induced hypertension and preeclampsia.

Her child was delivered at 7:00 p.m. via cesarean. She was sent to the recovery room and then to post-partum where she was put on an automatic blood pressure cuff which took her BP and read her pulse every ten minutes.

The physician's post-operative orders included checking the incision site and vagina for bleeding every half-hour and later every hour.

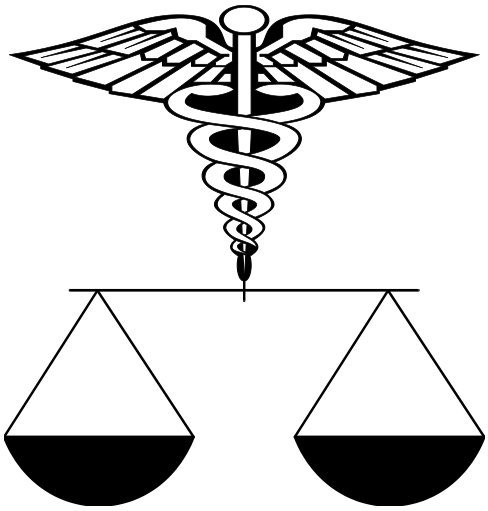
She was the only patient on the post-partum unit that night.

Her condition began to decline. Blood pressure and pulse were erratic and there was no urine output.

The patient's partner who remained at the bedside paged the nurse when the patient started sweating and having hot flashes, but there was no response.

The nurse finally arrived at 1:00 a.m. but the only assessment she charted was that the patient was resting comfortably. The BP, however, was quite low and the pulse was rising.

At 2:26 a.m. another nurse came in and picked up on the widening difference between systolic and diastolic pressures. She told the first nurse to give a bolus of IV fluid.



***The failure of the patient's obstetric nurse to appreciate the drastic fall in BP with a rise in her pulse and no urine output, classic signs of blood-loss shock, was a gross violation of the standard of care.***

***After the patient began to show signs of shock, not getting a physician to the room for twenty-five minutes was another violation.***

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
December 8, 2011

Twenty minutes later an alarm sounded for low diastolic pressure. By that time the patient was clammy, sweating profusely and unresponsive, having gone into hypovolemic shock.

The physician had to be called twice. He got to the patient's room twenty minutes after the second call.

When the patient was moved out of her bed for transport to surgery there was a significant amount of blood in the hospital bed that was apparently discovered for the first time then.

The patient was found to have suffered from disseminated intravascular coagulopathy related to HELLP syndrome, a severe complication of preeclampsia. She lost almost half her blood volume which resulted in a stroke and severe brain damage.

The US Court of Appeals for the Fourth Circuit believed that the patient's nurse could have prevented the patient from going into shock by monitoring the patient competently and could have prevented her from having a stroke when she went into shock by getting a physician to the room immediately. The Court approved a $900,000 judgment from the hospital for nursing negligence. **Creekmore v. Maryview Hosp., __ F. 3d __, 2011 WL 6091740 (4th Cir., December 8, 2011).**

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# Skin Care, ICU Patient: Court Accepts Nurse's Expert Opinion On Nursing Standard Of Care.

The patient, then sixty years of age, was admitted to the hospital for work-up of a fever which was found to be related to MRSA infection originating at the site of her renal dialysis shunt. The patient's medical diagnoses included end-stage renal failure, hypertension and diabetes.

In the hospital the patient's situation progressed to septic shock accompanied by respiratory failure which required that she be placed on a ventilator and transferred to the ICU.

Restraints were ordered in the ICU for both upper extremities. There were also standard hospital admitting orders in the chart for pressure-ulcer precautions.

Treatment in the hospital lasting more than a month was successful in resolving the MRSA-related sepsis, but after discharge the patient still had multiple pressure ulcers which started and progressed in the hospital that required ongoing aggressive treatment.

**Patient's Lawsuit Alleges Negligent Skin Care**

The patient sued the hospital for negligence related to the skin care she received while a patient in the hospital.

The Court of Appeals of Texas ruled that the expert opinions of a nurse and a physician submitted along with the filing of her lawsuit, as required in Texas and many other states, correctly stated the applicable standard of care and pointed out multiple breaches of the standard of care by the hospital's nurses.

**Nursing Expert's Opinion**
**Nursing Standard of Care**
**In General:**

1. Perform ongoing nursing assessments of the patient to identify actual and potential problem areas;

2. Make appropriate nursing diagnoses, i.e., alteration in comfort, alteration in hydration, alteration in skin integrity, alteration in elimination patterns, potential for urinary tract infection, etc., based on ongoing assessments;

3. Develop a comprehensive Plan of Care which sets out identified (actual or potential) problems and interventions designed to prevent adverse outcomes from known problem areas;

4. Implement Plan of Care;

***A nurse is qualified to give an expert opinion in court defining the standard of care for nurses and identifying specific breaches of the standard of care by the patient's nurses in their treatment of the patient.***

***The nurse must be able to satisfy the court that he or she has knowledge, skill, experience, training or education pertaining to the disputed issues in the lawsuit that qualify him or her to give an expert opinion on those subjects.***

***A nurse, however, is not accepted by the courts as qualified to give an opinion on the medical issues involved in linking a breach of the standard of care by a nurse to the harm suffered by the patient.***

***That requires testimony from a physician.***

***Being licensed as a physician does not automatically qualify someone as an expert witness.***

***In this case the patient's physician/expert had experience caring for patients with pressure ulcers, writing orders for nurses caring for such patients and evaluating nursing interventions. He is able to demonstrate familiarity with the medical consequences of substandard skin care.***

COURT OF APPEALS OF TEXAS
November 16, 2011

5. Evaluate patient's response to implemented Plan of Care; and

6. Update Plan of Care consistent with the patient's response.

**Standard of Care**
**Skin Care / Pressure Ulcers**
**In General:**

1. Conduct a pressure ulcer admission assessment for every patient using Braden Score Scale or Norton Score Scale;

2. Reassess risk for all patients daily using Braden or Norton;

3. Inspect skin of high-risk patients daily;

4. Manage moisture;

5. Optimize nutrition and hydration;

6. Reposition every two to four hours with $30^{o}$ lateral tilt;

7. Minimize pressure;

8. Once a pressure ulcer develops, the wound should be properly documented and photographed for the medical record: Color, size, depth, drainage, odor and progression should be documented.

Notify physician.

**This Patient:**

1. This particular patient should have been turned every two hours to prevent damage to the skin;

2. Proper bedding, i.e., an air mattress should have been provided to prevent pressure ulcers;

3. Once pressure ulcers developed the wound should have been properly documented and photographed for the medical record: Color, size, depth, drainage and odor. The physician should have been notified;

4. Upon discharge, wound care instructions should have been provided to the family and home health nursing staff; and

5. A therapeutic mattress should have been ordered for use at home.

The physician/expert went on to detail how failure to turn the patient every two hours prolonged the pressure on her sacrum and coccyx which diminished blood flow and caused damage to the tissue. If the progression of the lesions had been documented by the nurses the treating physician would have known to write orders for appropriate alterations of the care plan.

**Hillcrest Baptist v. Payne, 2011 WL 5830469 (Tex. App., November 16, 2011).**

# Patient's Fall: Nurse Should Have Stood By With The Patient.

The patient was having complications following hip-replacement surgery.

Because of deficits in his balance and movement his physician wrote an order that his nurse accompany him and assist him in returning to his bed any time that he got up to use his bathroom.

Despite the physician's orders, his nurse allegedly assisted him to ambulate from his bed to his bathroom and then left the hospital room while the patient was still in his bathroom.

The patient fell and was seriously injured when he tried to ambulate from his bathroom back to his bed.

The Court of Appeals of Minnesota ruled the physician's order left no room for professional judgment by his nurse how to assist him safely to the bathroom and back.

The patient's nurse was negligent for violating the nursing standard of care by failing to follow the physician's explicit order for stand-by assistance, the Court said. The patient did not need a nursing expert's opinion defining the standard of care to succeed in his lawsuit against the hospital. **Moore v. Park Nicollet Hosp., __ N.W. 2d __, 2011 WL 6306658 (Minn. App., December 19, 2011).**


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# E.R.: Psychiatric Patient Alleges Substandard Nursing Care, Court Dismisses Patient's Lawsuit.

***The E.R. nurse put the patient on suicide watch after he admitted he was suicidal and called security to prevent him from leaving the hospital until he could be evaluated by a physician.***

***That was an exercise of professional judgment. Expert testimony is required as to the standard of care for evaluating and treating a mental-health patient for the patient to be able to sue the hospital.***

***The legal rules are not changed by couching the lawsuit as one for battery, false imprisonment, intentional infliction of emotional distress and violation of the US Rehabilitation Act of 1973. A nursing expert still has to come forward and explain just what the nurses did that was wrong.***

UNITED STATES DISTRICT COURT
MINNESOTA
December 12, 2011

The patient had a history of depression, obsessive compulsive disorder and schizophrenia.

When he phoned the hospital's information line with questions about mental health treatment he was told to come in to the emergency department.

In the E.R. he was seen by a male nurse. The patient felt threatened by male nurses. The nurse asked him if he was suicidal and allegedly told him if he was he would be locked up and forced to take meds, whereupon the patient changed what he had said and said he was not suicidal.

The nurse decided to keep him anyway and put him on suicide watch. That meant sending him to a bare room with only a mattress on the floor. The nurse summoned two security guards when the patient balked at complying.

In the suicide-watch room another male nurse in came to draw blood. The patient asked for a female nurse, but none was provided. Several needle sticks were attempted before a sample was obtained. A large bruised area remained on the arm.

Then the first nurse came to the room to apologize for being abrupt with him earlier, but the patient would not see him.

The US District Court for the District of Minnesota dismissed the patient's case because the patient had no opinion from a nursing expert detailing what the nurses or the hospital did that was below the standard of care, that not being obvious from the facts. **Phillips v. Fairview, 2011 WL 6151514 (D. Minn., December 12, 2011).**

# Fire In The O.R.: No Attempt To Hide The Facts, Court Says.

The patient was having surgery to remove moles from her back and left eyebrow. She was under light sedation with oxygen running.

When the plastic surgeon activated the Bovie as he started to work on the eyebrow the spark caused a flash fire that was complicated by the oxygen that was running. The surgical team reacted quickly and put out the fire within seconds.

The patient had second-degree burns on the side of her face that left scars and still has problems with the eye.

***The plastic surgeon did not try to hide from the patient the fact that there was a fire. He got an immediate consult with a more experienced plastic surgeon and an ophthalmologist.***

COURT OF APPEALS OF OHIO
December 8, 2011

The Court of Appeals of Ohio stated that a patient can sue a healthcare provider for additional damages for fraudulent concealment on top of medical malpractice.

Nevertheless the Court disallowed $425,000 awarded by the jury for fraudulent concealment in addition to $871,359 awarded from the plastic surgeon for malpractice. The jury ruled the nurse anesthetist was not liable.

After the fire the patient's caregivers did what was required of them. They informed the patient that there was a fire and that she was burned by the fire, detailed the injuries caused by the fire and recommended appropriate treatment.

There was no obligation to admit fault in effect by going over the details of how the fire started, that is, no obligation to delve into the appropriateness of using the Bovie in close proximity with an oxygen source. **Wargo v. Susan White, 2011 WL 6152967 (Ohio App., December 8, 2011).**

# Latex Allergy: Nurses Held To Blame For Death From Anaphylaxis.

A twenty-nine year-old patient died in the hospital in 2000 from an anaphylactic reaction to latex products used during her gynecological surgery.

***The jury found the hospital liable for the patient's death due to the negligence of the hospital's nurses.***

***The jury exonerated the doctors from liability.***

COURT OF APPEALS OF MISSISSIPPI
December 13, 2011

The Court of Appeals of Mississippi approved a $4,691,000 verdict which expressly faulted the hospital's nurses for failing to follow the hospital's guidelines for admission screening of patients for potential latex allergy.

The adequacy of the hospital's guidelines was not called into question.

**Latex Screening**
**Nursing Responsibility**

The Court ruled it is a nursing responsibility to screen patients for latex allergy at the time of admission, assuming the hospital uses latex gloves or other products which pose a risk of allergic reactions.

If the patient has risk factors for latex allergy the nurses must communicate that fact to the treating physicians.

This hospital's policies called for the assessment form to be filled out completely, an allergy-alert sticker placed on the front of the patient's chart, signs hung on the door to the patient's room and central supply, purchasing and dietary notified.

The nurses neglected to ask the basic direct questions on the admission assessment form about prior experience with latex and less direct questions about certain food allergies that are common in latex-sensitive individuals and failed to probe for any and all prior allergic reactions in healthcare settings. **Mississippi Baptist v. Kelly, __ So. 3d __, 2011 WL 6157656 (Miss. App., December 13, 2011).**

# Lifting Restriction: Nurse Not Entitled To Reasonable Accommodation.

An LPN experienced an aggravation of an old on-the-job shoulder and neck injury making it impossible for him to lift more than twenty pounds on a regular basis. This restriction significantly limited his ability to perform patient-care tasks.

After continuing to work for several years with his restriction he had to retire when a scheduling change required him to work weekends and holidays when other nursing personnel would not be available to do all the heavy lifting for him.

***The accommodation sought by the nurse, permanent light-duty status, would put the burden on other nurses to do all the heavy lifting and perform other physical tasks he is not able to perform.***

***A person who seeks an accommodation that excuses him or her from the essential functions of the job is not a qualified individual with a disability.***

UNITED STATES DISTRICT COURT
MASSACHUSETTS
December 9, 2011

The US District Court for the District of Massachusetts found no disability discrimination and dismissed his case.

The courts have found no discrimination in other cases where a disabled employee was given light duty for a extended period time, an accommodation which the employer had no duty to provide in the first place which is eventually taken away.

The hospital in this case had no obligation to continue to ignore the essential functions of the job, repeated heavy lifting of patients by a staff nurse, even if that was done for a certain period of time. **Bourque v. Shinseki, 2011 WL 6148430 (D. Mass., December 9, 2011).**

# Discrimination: Nurse Did Not Follow Procedure, Case Dismissed.

A minority nurse was terminated after warnings, counseling, a performance improvement plan and progressive discipline did not resolve her job performance issues.

***The nurse was repeatedly counseled and was given a performance improvement plan, but that did not correct her behavior.***

***The hospital was within its rights to require nurses to sign out before leaving the cardiac cath unit, to insure there was always sufficient nursing coverage present.***

UNITED STATES DISTRICT COURT
NEW YORK
November 29, 2011

The nurse sued for discrimination, but the US District Court for the Western District of New York dismissed her case.

There was nothing discriminatory in the fact that other employees, non-minorities, were not required to sign out when leaving the cath lab. They were not patient-care nurses.

The Court said it is legitimate for a hospital to institute and enforce procedures to insure there is always adequate nursing coverage on the cardiac cath unit.

The nurse's allegations her supervisors were culturally disrespectful when they communicated her negative performance appraisals to her was not sufficient to make out a case of a racially hostile work environment, the Court ruled.

A racially hostile work environment, the courts have ruled, arises only when there is racially discriminatory intimidation, ridicule or insult so severe or pervasive as to alter the conditions of employment and create an abusive working environment. **Coley-Allen v. Strong Health, 2011 WL 5977792 (W.D.N.Y., November 29, 2011).**

# Lumbar Puncture: Patient Given Contraindicated Drugs, Nurses Ruled Partly Responsible.

***The patient's nurses were negligent.***

***The nurses did not stop two medications, namely Lovenox and aspirin, that are known to cause bleeding complications in a lumbar puncture.***

***The testimony was conflicting whether the physician gave orders for the nurses to discontinue these medications.***

***If the physician ordered these medications stopped, and the nurses failed to stop them, that is clear-cut negligence.***

***If the physician did not order them to stop the medications, the nurses should have realized the meds needed to be stopped and contacted the physician and, if necessary, gone to their nursing supervisor.***

***The nurses apparently did not appreciate the potential side effects of the medications they were giving before and after a lumbar puncture.***

***The nurses failed to identify the need for an MRI after signs of complications began to appear.***

***The nurses failed to recognize the catastrophic neurological changes the patient was having.***

COURT OF APPEALS OF TEXAS
December 12, 2011

The patient came to the E.R. in the early a.m. hours with symptoms of a severe headache and a stiff neck. The physician ordered a number of tests to try to find out what was going on.

The physician ordered aspirin and Lovenox, blood thinners, twice daily. The first dose was given at noon and the next at midnight. The physician also ordered a lumbar puncture.

The lumbar puncture was scheduled for mid-afternoon the next day. The patient got his aspirin and Lovenox at noon before the procedure and again at midnight afterward.

The following day he began to develop signs and symptoms of a spinal hematoma, back pain, loss of feeling in his legs and inability to urinate. The neurologist who did the lumbar puncture was contacted and ordered an immediate spinal MRI. Although ordered at 6:00 a.m. the MRI was not done until 3:00 p.m. the next day, thirty-three hours after being ordered.

The patient never recovered from the spinal hematoma despite a neurosurgical intervention at a tertiary care facility and is now a paraplegic.

**Nurses Ruled Negligent**

The Court of Appeals of Texas ruled that the patient's nurses were negligent. They should have known that anti-coagulant medication is contraindicated in conjunction with a lumbar puncture due to the grave risk of the very same complications this patient actually experienced.

The case was complicated legally by the fact the nurses, who were sued individually along with the hospital and the treating physicians, settled with the patient before the case went to trial.

The Court ruled that the jury in the trial should have been instructed to weigh the extent the nurses' negligence contributed to the unfortunate outcome so that the physicians and the hospital would only have to pay their proportionate shares. The jury found the physicians in total 85% responsible, which may not have been exactly correct, so a new trial was ordered. **Janga v. Colombrito, __ S.W. 3d __, 2011 WL 6146197 (Tex. App., December 12, 2011).**

# Intoxicated Jail Inmate: Nurse Found Not Guilty Of Negligence Or Deliberate Indifference.

The motel manager called the police to report that an intoxicated guest was causing a commotion. The police believed he was so drunk as to be a danger to himself and called paramedics who transported him to the county jail.

The inmate suffered a stroke at some point during the night in the jail holding area. He sued the jail nurse and the county for common-law medical negligence and for violation of his Constitutional rights.

Deliberate indifference to an inmate's serious medical needs by jail officials, including medical or nursing personnel, is recognized by the courts as a form of cruel and unusual punishment forbidden by the Eighth Amendment to the Constitution and grounds for a civil-rights lawsuit.

The US Court of Appeals for the Tenth Circuit dismissed the case.

**Jail Nurse Performed Competent Neuro Assessments**

The jail nurse testified to the Court's satisfaction that he knew the signs of a stroke, including hemispheric drooping of the face, slurred speech, dizziness, limping, neurological deficits and elevated BP.

The nurse recorded his initial assessment that the inmate's pupils and grip strength were equal bilaterally and his BP and Glasgow Coma Scale were within normal limits. Slurred speech, dizziness, confusion and ringing in the ears the nurse attributed to alcohol intoxication, the patient having been very obviously under the influence when he was brought in.

The nurse got a BP and re-did the Glasgow Coma Scale at least four times over the six hour period he was in the holding cell. When his BP rose the nurse gave him Gatorade to help rehydrate him.

When the inmate patient collapsed at 6:00 a.m. the nurse was instrumental in getting him sent to the hospital for further evaluation which revealed he had had a stroke sometime during the night.

The Court ruled nevertheless that the nurse's assessments, evaluation and care were completely appropriate at the time. Hindsight as to the outcome is not grounds for a lawsuit. **Childress v. Harms, 2011 WL 6016917 (10th Cir., December 5, 2011).**

***When the inmate was sent to the hospital the doctors determined he was not only drunk but also had had a stroke in the jail.***

***Hindsight as to the outcome is not relevant. The only relevant issue is the healthcare provider's knowledge at the time of his or her assessments, evaluations and treatment.***

***The inmate was obviously intoxicated when the police officers brought him in.***

***The jail nurse interviewed the inmate and repeatedly checked his vitals, measured his Glasgow Coma Scale and monitored him closely in the holding cell.***

***The nurse satisfied the Court through his testimony that he was very familiar with the signs and symptoms of a stroke and actually did perform competent nursing neuro assessments of his patient.***

***When the inmate patient collapsed in the holding cell, it was the nurse who thought there could be something more going on besides alcohol intoxication and alerted the doctor so that the decision could be made to send the patient to the hospital for evaluation.***

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT
December 5, 2011

# Medication Mix-Up: Hospital Pays For Nurse's Error.

The baby's teenage mom and dad brought her to the E.R. because she was fussy, running a fever and vomiting and the Infants' Tylenol they were giving her was apparently not helping.

The baby was discharged with oral instructions from the nurse to give her a teaspoon of Tylenol every four hours. The nurse was referring to the Children's Tylenol the hospital used, but the parents gave the baby the Infants' Tylenol they had been using, which is more than three times as concentrated. The child died from liver failure caused by acetaminophen toxicity.

***The hospital used Children's Tylenol exclusively, which is three times less concentrated than the Infants' Tylenol the parents had been giving the child.***

***The nurse simply told the parents how often to give a full teaspoon, which was a major overdose since the parents were using a more concentrated product.***

***The nurse did not give the parents the manufacturer's printed dosage sheet with correct doses for different Tylenol products, a violation of hospital policy.***

COURT OF APPEAL OF LOUISIANA
December 7, 2011

The Court of Appeal of Louisiana approved a verdict finding the hospital 70% at fault and the parents 7% at fault.

The manufacturer of Tylenol appealed it's 23% allocation of fault unsuccessfully. Most of the Court's lengthy opinion dealt with products-liability law. The manufacturer's financial exposure for a fractional share of the multimillion dollar jury verdict is not limited like the hospital's by Louisiana's cap on medical malpractice damages. **Hutto v. McNeil, __ So. 3d __, 2011 WL 6058038 (La. App., December 7, 2011).**

# Slip And Fall: Hospital Visitor Can Sue.

A visitor was injured in a slip and fall accident in a hospital corridor while she was bringing a patient's young son to visit his mother in the hospital.

***Three nurses responded immediately when the visitor fell. One of the nurses remarked that a nurse must have spilled the water on the floor while going from room to room filling patients' water pitchers.***

***Even if that was not the case, the spilled water on the floor was in plain view from the nurses station.***

***Either way, hospital employees apparently were aware of the hazard and the need to take action before the accident happened.***

COURT OF APPEALS OF MISSISSIPPI
December 16, 2011

The Court of Appeals of Mississippi rejected the hospital's legal argument that there is a lesser degree of responsibility owed by a hospital to a visitor than the duty of care owed to a patient.

There is no logical reason for such a rule and the courts in other jurisdictions that have ruled on this specific question have treated visitors exactly the same as actual patients in premises-liability cases, the Court pointed out.

**Nurse Admitted Liability**

The strongest evidence against the hospital, the Court said, was an offhand remark the visitor overheard from one of the nurses who came to help her when she fell, to the effect that another nurse must have been the one who spilled the water on the floor.

Statements by hospital employees are not hearsay and can be used in court against a hospital to prove liability. **Wilson v. Baptist Memorial, __ So. 3d __, 2011 WL 6157659 (Miss. App., December 13, 2011).**

# Long-Term Care: Court OK's Civil Monetary Penalty For Violations Of Federal Standards.

State survey inspectors found numerous instances of non-compliance with Federal Medicare regulations at a long-term care facility and imposed a civil monetary penalty which was upheld by the US Court of Appeals for the Tenth Circuit.

***These violations placed the facility's residents in immediate jeopardy, the most serious negative rating a facility can be given.***

***The civil monetary penalty was $6,500 per day until the jeopardy was corrected.***

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
December 16, 2011

**Failure to Consult With Physician After Significant Change In Physical, Mental or Psychosocial Status**

Several of the facility's diabetic residents had blood sugars recorded in their charts in the 20-40 mg/dl range.

It was recorded that one was convulsing and had cold and clammy skin. Another was lethargic, twitching, mumbling and staring blankly. Another was groggy and unable to walk. Yet another was cool, clammy, sweaty and slow to react.

The Centers for Medicare & Medicaid Services (CMS) Review Board accepted testimony from its own nursing expert that a blood sugar below 60 mg/dl with additional signs of low blood sugar is a significant change in status that triggers the duty to consult with the resident's physician. CMS's expert went on to state that a blood sugar below 60 mg/dl can cause seizures, coma and death.

CMS conceded that the 60 mg/dl parameter is not expressly stated in any Federal statute or regulation. However, each of the residents had orders to call the physician if the blood sugar was below 60 mg/dl and, on the whole, it is a reasonable interpretation of the regulations defining when a diabetic resident's physician must be contacted, the Court said.

**Residents' Right to Be Free Of Significant Medication Errors**

One of the residents came to the facility with conflicting hospital discharge orders for the Tegretol she was to receive. That is, one note said 200 mg/day and another said 400 mg/day.

Instead of phoning the hospital or the physician for clarification someone at the nursing home simply transcribed the larger order into the chart. The patient received the larger dose for forty-three days until the error was discovered and corrected.

A medication error is significant, for purposes of compliance with Federal regulations, if it has the potential for serious consequences. It is not relevant whether the resident could have or actually did pull through without complications.

Another resident had a similar problem with her insulin. The hospital discharge form noted she had been getting 55 units in the morning and 40 at night before hospitalization and also said that her current medications included 20 units in the morning and 10 at night.

The nurse who transcribed the orders decided the lower numbers must be correct and that was how the patient was medicated until the problem was discovered. A nurse practitioner eventually changed the p.m. dose to 30 units, meaning that neither the larger or the smaller dose was what the patient actually should have been getting.

Again the ambiguity in the hospital discharge paperwork required a nurse to seek clarification from the hospital or the physician rather than making an assumption that has no factual basis.

The Court ruled this was a significant medication error as the word significant is used in the regulations, significant in that it revealed a substandard nursing practice that held the potential for serious jeopardy to residents' health and safety.

Actual harm is not required to find that immediate jeopardy exists if noncompliance at the facility is likely to cause serious injury, harm, impairment or death to a resident, the Court pointed out. **Life Care Center v. Secretary of HHS, 2011 WL 6275916 (6th Cir., December 16, 2011).**

LEGAL EAGLE EYE NEWSLETTER
*For the Nursing Profession*

# Unfair Labor Practices: Aide Fired, Urged Patients To Support Union's Cause.

The National Labor Relations Board ruled that a nursing home located in Pennsylvania was guilty of unfair labor practices for disciplinary actions taken against a nursing assistant who was an outspoken union supporter and had urged patients to support the union's cause.

The US Court of Appeals for the District of Columbia upheld the Board's ruling.

The Board determined that the nursing home first acted unlawfully by confronting the aide and taking her aside for an interrogation session in which she was allegedly told to stop worrying about the union and start worrying about her job. That amounted to illegal coercion in violation of the National Labor Relations Act.

The nursing home also confiscated pro-union literature from the aide, another violation of the aide's rights guaranteed by Federal law.

The aide was expressly warned to cease and desist from her union activities. She was specifically warned to stop urging the nursing home's patients to support the union cause.

Then she was fired for violating that, her last and final disciplinary warning which she had been told could lead to her termination.

The Court pointed out that the National Labor Relations Act makes it an unfair labor practice to discourage membership in any labor organization by discriminating in regard to hire or tenure of employment.

The nursing home admitted that her union activities were a motivating factor in her termination. The nursing home nevertheless argued in its defense that there were other non-union-related disciplinary issues with this aide and that her firing for urging union support from patients was only the final culmination of that process.

The Court rejected that argument. Other employees with similar disciplinary histories who were not involved in pro-union activities were not fired over their other issues.

That confirmed for the Board that the aide's protected pro-union activities were not just one factor but basically the sole reason the nursing home decided to terminate her. The nursing home would have won its case if it could have proven that other factors were the principal motivation for firing her, but that was not what happened here, in the Court's judgment. **Manor Care v. N.L.R.B., __ F. 3d __, 2011 WL 5839631 (D.C. Cir., November 22, 2011).**

# Sexual Abuse, Mandatory Reporting: Nurse Did Not Report, But Court Orders License Restored.

An advanced practice RN had her license placed on suspension for two years after it came to the attention of her state board that she did not report to law enforcement what she heard about two boys, acquaintances of her grandchildren, having sexually abused three younger children.

Her adult daughter told her what she heard from her children, the nurse's grandchildren, that their young friends had told their own mother.

The nurse contacted the victims' mother and strongly urged her to take the children to a local children's hospital for evaluation and treatment, but she did not report to local law enforcement what she had heard.

The Superior Court of Delaware looked at the state's mandatory reporting law and ruled in the nurse's favor.

***It is necessary to look closely at how the sexual abuse mandatory reporting statute is worded and interpreted.***

***The Court's interpretation is that the mandatory reporting statute, as it was worded at the time of the events in this case, referred only to information which a nurse or other professional on the list obtains in connection with professional practice.***

SUPERIOR COURT OF DELAWARE
November 17, 2011

A long list of professionals who come in contact with children in their professional capacities, physicians, nurses, psychologists, social workers, school employees, etc., are required to report known or suspected child sexual abuse to law enforcement. Failure to do so is a crime and grounds for discipline against the professional's license.

The Court ruled, however, that suspension of the nurse's license was not justified. The Delaware mandatory reporting law was recently amended to include *all persons* in the list. However, as the law was worded and interpreted by the courts at the time of the events in question it only mandated reporting of abuse learned about by a professional on the list in connection with professional practice. **Gillespie v. Del. State Bd. of Nursing, 2011 WL 6034789 (Del. Super., November 17, 2011).**