LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

July 2008 Volume 16 Number 7

Patient's Seizure: Court Rules Nurse's Slow Response Is Neglect Of A Vulnerable Adult.

The nursing home resident herself reported to the nursing staff she had had a seizure lasting about two minutes at 6:15 a.m.

At 7:00 a.m. the same morning a CNA entered the resident's room, saw her arms and legs twitching and went into the hallway and asked for help from the first registered nurse to be found.

Although not assigned to care for this resident the RN went in immediately, quickly assessed the resident and lowered the bed so the resident would not injure herself.

Then the RN went to the nurses station, told the charge nurse she did not know what to do and asked the charge nurse for direction.

The charge nurse told her to go back to the room and activate the resident's vagal nerve stimulator.

The RN spent fifteen minutes reviewing the patient's chart trying to familiarize herself with the procedure for external activation of the implanted vagal nerve stimulator before she finally did what she had just come to understand was needed to activate the device.

The RN then watched and waited ten more minutes while nothing appeared to be happening to halt the seizure. Then she phoned and left a message for the on-call neurologist.

Neglect includes failure by a caregiver to supply a vulnerable adult with care or services reasonable and necessary to maintain physical or mental health or safety.

A vulnerable adult is an individual in a nurse's care who has a physical or mental infirmity that impairs the individual's ability to care for himself or herself.

COURT OF APPEALS OF MINNESOTA
May 21, 2008

The neurologist called back five or ten minutes later and told the RN to call 911 and get the resident to an E.R.

When the paramedics arrived the patient was unresponsive in a generalized tonic-clonic seizure. She had a 103° temp, 166 pulse and low blood O_2 sat. The paramedics cleared the airway, started O_2, gave IV meds to halt the seizure and transported the resident to the hospital where she was admitted to the ICU in critical condition.

After Three or Four Minutes Nurse Must Ask For Assistance

The Court of Appeals of Minnesota agreed with the state department of health adjudicators that when a seizure has lasted at most three or four minutes a nurse must call for emergency medical assistance. According to the court, at that point a nurse must realize that what he or she has been doing for the patient is not working and the patient is in grave danger.

The RN's own testimony was clear evidence, the court said, that forty minutes elapsed from the point when the CNA first brought the crisis situation to the RN's attention before emergency paramedics were called and that ten more minutes elapsed before the paramedics arrived, stabilized the situation and took the patient to the hospital for critical care. **Charles v. Dept. of Health, 2008 WL 2168270 (Minn. App., May 21, 2008).**

Inside this month's issue ...

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New Subscriptions
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Patient Safety: SNF Did Not Enforce Its Own Smoking Rules, Civil Monetary Penalty Imposed.

The US Court of Appeals for the Fourth Circuit recently upheld a civil monetary penalty against a skilled nursing facility in North Carolina of $3050 per day for 52 days the facility was not in compliance with Federal patient-safety regulations.

Staff regularly and flagrantly violated the facility's own safety policy for resident smoking. The policy, on its face fully compliant with CMS standards, was that patients were not to have cigarettes or lighters on their persons or in their rooms and could only smoke outside on the fenced patio with stand-by staff supervision.

Resident #1

One resident, a chronic heavy smoker, had some mild dementia along with COPD. His dementia tended to get worse and he got confused when he went without his O_2 which he usually took off to smoke. He was caught smoking in his room twice but still was allowed to keep his cigarettes and his lighter. He lit a cigarette in his room at 2:00 a.m. with his O_2 on, was badly burned and had to be rushed to the E.R.

Resident #2

Another heavy smoker typically did follow the rules by smoking only on the outdoor fenced-in patio that was designated as the smoking area. However, since he smoked so often during the day he usually went outside with no staff supervision. One day the gate was unlocked and the alarm was turned off. He wandered away and was found smoking at a picnic table that was the staff smoking area behind a nearby medical office complex.

Systemic Problem

Most Severe Penalty Imposed by CMS

State survey inspectors, called in after the first resident burned himself, found a pattern of staff informally designating certain residents as "safe" smokers and letting them keep their cigarettes and lighters and smoke by themselves when and where they wanted, a clear violation of the facility's own policy and, as such, a violation of Federal regulations. **Century Care v. Leavitt, 2008 WL 2385505 (4th Cir., June 11, 2008).**

CMS regulations found at 42 CFR § 482.25 http://www.nursinglaw.com/qualityofcare.pdf require skilled nursing facilities to take reasonable steps to prevent accidents and to maintain residents' physical, mental and psychosocial well-being.

Violations are classified on a spectrum ranging from "no actual harm with a potential for minimal harm" all the way to "immediate jeopardy to resident health or safety."

The seriousness of the violation determines the amount of the civil monetary penalty assessed.

Residents informally designated as "safe" smokers could keep their cigarettes and lighters and smoke by themselves when and where they wanted.

One resident was burned smoking alone in his room with his O_2 going. Another resident eloped from the outdoor smoking area through an unlocked gate.

These were systemic rather than isolated or episodic deficiencies in patient safety and they have to be classified as the most serious violations possible.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
June 11, 2008

Nurse/Therapist: Patient Awarded Damages Over Improper Sexual Relationship.

A female client sued her male nurse/clinician for malpractice.

The client's lawsuit hinged on expert testimony from a clinical psychologist that the nurse/clinician took advantage of paternal transference she developed toward him in therapy and encouraged her to start up a sexual relationship with him.

The nurse/clinician denied any sexual relationship. He claimed the patient's lawsuit was retaliation against him for terminating therapy. He also brought in a forensic psychiatrist who reportedly delved into the patient's history of making similar claims of abuse in other therapeutic contexts and against people in former workplaces.

A jury in the Superior Court, Middlesex County, Massachusetts, awarded the former client $48,000. **Merrill v. Colbert, 2008 WL 2437663 (Sup. Ct. Middlesex Co., Massachusetts, March 10, 2008).**

Patient Suicide: Family Obtains Settlement.

The patient had been in and out of the same E.R. for several days expressing suicidal thoughts.

The E.R. nurse had a nurse from the psych unit come down and see him. The psych nurse recognized the patient needed help but apparently left him unattended in an exam room while she went to speak with the E.R. physician who was balking at admitting him. The patient left the hospital, went home and hanged himself.

The family's lawsuit in the Court of Common Pleas of South Carolina settled for $1,000,000. **Estate of Wright v. Amisub, 2007 WL 5145059 (Ct. of Com. Pl. of South Carolina, May 22, 2007).**

Acute Pancreatitis: Patient's Lawsuit Alleges Sub-Standard Nursing Care First Day In The Hospital.

The diabetic patient came to an emergency room with abdominal pain. He was promptly diagnosed with acute pancreatitis and admitted to a med/surg unit.

The next day he was transferred to another hospital. There it was discovered that he was seriously dehydrated and had seriously elevated blood glucose.

Notwithstanding intensive medical interventions at the second hospital he was left with irreversible brain damage.

A lawsuit was filed on his behalf against the first hospital for medical and nursing negligence. The Court of Appeals of Texas believed the nursing and medical expert witness opinions supporting the patient's lawsuit were right on the mark and ruled the lawsuit could go forward.

Nursing Negligence

The patient's nursing expert listed multiple errors and omissions in the patient's care at the first hospital.

The nurses did not take vital signs frequently and report changes to the physician. Nor were frequent finger-stick blood glucose readings obtained or reported to the physician. The patient was not on O_2 and did not have an O_2 sat monitor.

The nurses did not request a nasogastric tube for the patient who was NPO.

The patient's deterioration was not addressed by the medical staff due to substandard monitoring of and response to his changing health status by the hospital's med/surg nurses.

He rapidly sank into dehydration and diabetic ketoacidosis which led to cerebral edema and irreversible brain damage.

The patient's lawsuit against the hospital stands on solid ground.

The lawsuit is supported by an expert opinion from a registered nurse detailing specific errors and omissions by the nurses.

The lawsuit is further supported by a physician's expert opinion detailing substandard medical care, much of which can be linked to inadequate data-gathering by the patient's hands-on nursing caregivers.

COURT OF APPEALS OF TEXAS
May 22, 2008

Fluid balance is critically important with a patient who is NPO and at the same time losing fluid large amounts of fluid through the kidneys from diuresis brought on by hyperosmolar blood glucose levels.

The nurses should have been monitoring input and output and reporting to the physician so that the IV fluid infusion rate could be set to match the major fluid losses the patient was experiencing.

From the records it could not be verified that the nurses gave any of the insulin that the doctors ordered. **San Jacinto Methodist Hosp. v. Carr, 2008 WL 2186473 (Tex. App., May 22, 2008).**

Coumadin: Med Started Before Lab Tests Back.

A nursing home resident's physician ordered lab tests to determine her suitability for Coumadin, but the nursing staff apparently went ahead with the Coumadin before the labs results came back and were evaluated by the physician. The patient had to be hospitalized after she began spitting up blood and bleeding rectally.

The patient's lawsuit in the Superior Court, Riverside County, California settled for $100,000. **Incardone v. Ben Bennett Inc., 2008 WL 1847175 (Sup. Ct. Riverside Co., California, March 17, 2008).**

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Emergency Care: Hospital Had No Obstetric Department, Judge Finds No Negligence Committed By E.R. Physician Or Nurses.

An infant was born at twenty-five weeks in the emergency department of a hospital which does not have a labor and delivery unit or a neonatal intensive care unit and does not offer obstetrical services. The child now has cerebral palsy and is badly developmentally delayed.

The Court of Appeal of California upheld the lower court's finding of no neligence by the E.R. physician and nurses.

Nursing Assessments

After initial triage, a nurse carried out orders for a Foley catheter. Although she did not chart that there was no bleeding she testified she would have charted and reported it if there was any.

Another nurse took the patient for an ultrasound, waited for her, returned her to the emergency department and again took her vital signs. The ultrasound, two hours before the spontaneous birth, was normal for the fetus's gestational age.

A nurse saw no bleeding when the nurse helped the patient use a bed pad to try to defecate. When the patient said she wanted to start pushing the nurse told her not to push before talking to the physician. The nurse reported this to the physician and then charted what happened.

When the water broke a nurse came into the examination area promptly at the family's request. Right then the baby came out. It was in severe respiratory distress. The physician had to bag the newborn by mouth after trying and failing to intubate with the smallest pediatric tube they had. The baby was transferred to a neonatal ICU at another hospital later that night.

The court ruled the hospital fulfilled its emergency medical screening and stabilization requirements under the US Emergency Medical Treatment and Active Labor Act. Based only on the data known before the birth the mother could not have been transfered legally to another facility.

Valdepena v. Catholic Healthcare, 2008 WL 2469374 (Cal. App., June 20, 2008).

The emergency room nurses did all that was expected of them in terms of assessing, evaluating and monitoring the patient's changing condition.

Almost immediately upon arrival in the E.R. lobby the triage nurse wheeled the pregnant patient into an examination area and obtained her history, that is, that she was eighteen years old, pregnant and had come to the hospital because of vaginal bleeding along with sharp lower abdominal pain lasting thirty minutes.

The nurse took vital signs. Then the nurse used a handheld Doppler, all that was available, to obtain a fetal heart rate of 155. If there were any labor contractions the highly experienced E.R. nurse would have felt them.

The patient was classified as urgent but not critical. The nurse reported right away to the E.R. physician and checked on the patient from time to time until the physician saw her seventy minutes later. She did not need any more pads, so her bleeding was not significant.

CALIFORNIA COURT OF APPEAL
June 20, 2008

Failure To Thrive: Arbitrator Finds No Negligence.

The seventy-nine year-old patient was in and out of the hospital with multiple medical conditions including diabetes, hypertension, coronary artery disease, high cholesterol, hypothyroidism, urinary tract infections, morbid obesity and degenerative disc disease.

The hospital's psychiatric service was called in on at least one occasion to evaluate the patient's apathy and unwillingness to participate in her own care.

The patient was transferred back and forth between a skilled nursing facility and the hospital for treatment of gastrointestinal bleeding from a duodenal ulcer, dehydration and altered mental status.

Failure to Thrive

Caregivers Recommended Palliative Care

The treatment team eventually sat down with the family and discussed their diagnosis of failure to thrive. They recommended palliative care in a hospice, but the family did not want to give up.

The family requested a percutaneous gastrostomy feeding tube. The physicians put it in and sent the patient back to the skilled nursing facility, where she died.

The family believed malpractice was involved in her death. The hospital and skilled nursing facility were associated with an HMO which contracted for arbitration.

The neutral arbitrator heard all the evidence as to alleged errors and omissions in the management of the patient's complex medical issues allegedly responsible for the patient's demise. Representatives from the hospital and nursing facility testified as to their efforts to make the patient as comfortable as possible, attend to her skin care, urge her to take nourishment but ultimately to allow her to pass.

The arbitrator endorsed the patient's caregivers' approach, saw no negligence and awarded the family nothing by way of damages.

Ulmer v. Kaiser Permanente, 2007 WL 5256757 (Medical Malpractice Arbitration, California, November 14, 2007).

Pressure Sores: Court Case Relates Patient's Death To Sub-Standard Skin Care.

The elderly patient was admitted to long-term care with diagnoses of Alzheimer's, left carotid artery stenosis, non-insulin-dependent diabetes, renal insufficiency, arthritis and osteoarthritis.

New pressure sores started and over the next year progressed to Stage III decubitus ulcers followed by osteomyelitis and a below-the-knee amputation. The patient never fully recovered after the amputation, came down with pneumonia and died.

Nurses in a nursing home must:

Inspect and assess the skin, head to toe, every day, with particular attention to pressure points such as heels, toes, hip and sacrum;

Document new skin changes on the very day they are noted;

Perform a regular and detailed documented skin assessment once a week; and

Treat pressure sores in the early stages as soon as they are discovered.

COURT OF APPEALS OF TEXAS
May 22, 2008

The Court of Appeals of Texas accepted the deceased's family's expert physician's opinions on the standard of care for nurses in long term care. The court went on to concur with the physician's opinion that an untreated or improperly treated pressure sore can be the starting point of a progressive downward spiral leading to the patient's ultimate demise. **Arboretum Nursing and Rehab v. Isaacks, 2008 WL 2130446 (Tex. App., May 22, 2008).**

Pressure Sores: Court Case Points Out Importance Of Hydration And Nutrition.

According to the Court of Appeals of Texas, when a patient is admitted to long-term care the patient must get a thorough survey of skin integrity and assessment of potential for skin breakdown.

The skin-care care plan should:

Cover the nursing and medical interventions needed to treat existing lesions;

Provide for ongoing reassessment of the skin and of medical issues that could predispose the resident to problems with skin integrity; and

Set goals to promote adequate hydration and good nutrition. **San Jacinto Methodist Hosp. v. Bennett, __ S.W. 3d __, 2008 WL 2262082 (Tex. App., May 29, 2008).**

Evidence of longstanding substandard care emerged when the patient had to be transferred to the hospital for skin grafts.

The first lab values in the hospital were consistent with prolonged dehydration and malnutrition. Her BUN/ creatinine ratio was well above and her albumin and pre-albumin levels were well below the normal ranges.

A nursing home must consistently promote adequate hydration and good nutrition, assess and treat the skin of an immobile elderly resident and pad and position critical areas of the body against further breakdown of skin integrity.

COURT OF APPEALS OF TEXAS
May 29, 2008

Code: Crash Cart Not Stocked, Other Equipment Non-Functional, Patient Dies, Family Sues.

A wrongful-death lawsuit filed in the Superior Court, Essex County, New Jersey, recently resulted in a $1,300,000 settlement for the family of a sixty-eight year-old patient who died in the hospital four hours after thyroid cancer surgery, one hour after being transferred from intensive care to a med/surg unit.

Defendants named in the lawsuit, besides the hospital, included three staff nurses from the med/surg unit, the hospital's director of nursing, the pharmacy director and the head of central supply.

Equipment, Supplies Missing Equipment Failed

The patient went into respiratory arrest with a blood clot blocking her upper airway. A code was called.

The first thing that went wrong was that the batteries in the laryngoscope on the crash cart were dead and no spare batteries for it had been stocked on the cart.

Next the wall-mounted suction in the patient's room would not work.

The lawsuit also alleged the med/surg nurses hesitated for thirty to forty-five minutes from the time they first saw signs of respiratory difficulty until a code had to be called because the patient had gone into full-blown respiratory arrest.

The Defendants Pointed Their Fingers At Each Other

The hospital was reportedly prepared to defend itself by pointing out it had a policy for extra batteries to be packed with laryngoscopes.

The med/surg staff nurses reportedly were going to argue it was not a nursing responsibility to stock or inspect the crash cart, shifting the blame to the hospital's central supply department.

Nevertheless all the parties joined as defendants joined in paying a substantial settlement. **Fregosi v. Clara Maas Medical Ctr., 2008 WL 2189884 (Sup. Ct. Essex Co., New Jersey, May 12, 2008).**

Deep Vein Thrombosis: Patient's Death Tied To Nursing Negligence.

The patient was discharged home after eight days in the hospital recovering from surgery to remove a cancerous tumor from his lung. The surgery was judged a success by his treating physicians.

At the time of discharge the patient apparently was not instructed by his nurse to continue wearing his compression stockings, nor was he given compression stockings to take home with him from the hospital.

His left foot and ankle swelled two days out of the hospital. The patient's wife phoned the hospital twice and spoke with two different nurses.

The first nurse told the wife to make sure her husband continued wearing his compression stockings. The wife replied that he was never given any compression stockings when he left the hospital but the nurse reportedly said nothing in reply.

The second time the wife phoned she reportedly was told there was no reason to be alarmed about his swollen foot and ankle but if it got any worse she should take him to the emergency room.

Cardiac Arrest / Death Caused By Pulmonary Embolism

The patient began having trouble breathing and went into cardiac arrest shortly after his wife's second phone call to the hospital.

Paramedics rushed the patient to the hospital E.R. He was revived but then suffered two more episodes of cardiac arrest and died.

Evidence was given at trial in the Circuit Court, Jackson County, Missouri that the arrest was caused by a pulmonary embolism from a deep vein thrombosis. The jury awarded the widow $1,300,000 from the hospital for the nurses' negligence. **Phillips v. Saint Luke's Health System, 2008 WL 2434180 (Cir. Ct. Jackson Co., Missouri, March 6, 2008).**

Cardiac Patient Left Unattended On Commode: Jury Awards Damages For Nurse's Negligence.

The patient had double coronary artery bypass surgery with mitral valve repair. The next day the pacemaker was removed in the O.R. and she went back to the ICU on epinephrine, Primacor, dobutamine and amiodarone, medications intended to normalize her problematic heart beat.

Four days after surgery she was transferred from the ICU to the telemetry unit. Transfer orders to the telemetry unit included progressive ambulation with assistance, discontinuance of her dopamine and Lasix drips, removal of her Foley catheter and bathroom privileges with assistance.

The patient said she had to urinate. A family member asked the CNA for the bedpan. The CNA replied it was better for her to try to get up and walk to the bathroom. The patient and her family balked at the idea of her getting out of bed so the CNA went to get the patient's nurse.

The patient's nurse assisted her from her bed to the bathroom, which took almost two minutes, then left her on the commode.

The jury apparently believed testimony from the CNA and the family that the CNA found the patient on the floor in the bathroom almost twenty minutes later, about the same time a different nurse caught an alarm at the telemetry station and went to the room to investigate.

The patient had gone into cardiogenic shock from stoppage of her left ventricular heart rhythm. She lived on, but with organ damage and other complications.

The Court of Appeals of Michigan endorsed a jury verdict in the patient's favor for nursing negligence for leaving a complex cardiac patient alone on the commode without stand-by assistance. **Barber v. William Beaumont Hosp., 2008 WL 2151382 (Mich. App., May 22, 2008).**

Anemic Patient Left Unattended In Shower: Hospital Pays Settlement For Nurses Aide's Negligence.

The sixty-two year-old patient was admitted to the hospital for generalized weakness, memory loss, confusion, bilateral pedal edema and unsteady gait.

Lab tests disclosed severe thrombocytopenia, anemia and hyperglobulinemia.

The initial nursing assessment was that he had an increased risk of falling.

The patient reportedly asked the aide assigned to assist him with activities of daily living to allow him to go and shower by himself, and the aide agreed.

While in the shower by himself the patient fell. He sustained a subdural hematoma from which he died three months later.

His family filed suit in the Superior Court, Los Angeles County, California. The hospital paid $107,500 to settle before trial, on top of $150,000 paid by the physician who provided post-injury treatment.

Aide Violated Hospital Policy

The hospital reportedly had a strict policy that patients were never to be left alone in the bathroom, a policy which the aide violated.

A traditional battle of the expert witnesses would not have occurred in court if the case had not settled. When a facility's own internal patient-safety policies are violated it is superfluous for the patient or the family to have to bring in experts to establish the prevailing standard of care.

The lawsuit went on to fault the professional nursing staff over training and supervision of non-licensed caregivers.

It was also claimed the patient's nurses were slow to advocate for a full medical assessment after his fall. **Bass v. Mitchell, 2008 WL 2189931 (Sup. Ct. Los Angeles Co., California, April 23, 2008).**

Psychiatric Nursing: Patient Dies During "Take-Down," US Court Imposes Supervisory Responsibility, Liability On Nurses.

A man with a history of mental illness was taken to a community mental health facility by sherriff's deputies who found him out wandering the countryside.

The facility's designated mental health professional gave the deputies permission to detain him and told them to take him to the local psychiatric hospital. At the hospital the patient reported auditory and visual hallucinations and suicidal thoughts. He was also shaking uncontrollably for reasons not immediatly apparent.

The patient signed papers consenting to voluntary admission and treatment.

He spent the rest of the night in a quiet room at the psychiatric hospital pending the physicians' decision whether to start him on pychotropic medications, a medical decision that required time for toxicology results to come back indicating what psych meds, other meds and/or illicit substances were already present in his bloodstream.

In the morning the patient became highly agitated. He paced in circles in the hallway talking to himself and trying to open the doors to other patients' rooms.

A hospital staff physician decided to go ahead with 2 mg of Ativan right away. While the nurse was getting the medication the patient attacked a psych treatment aide. A take-down code was called and several more aides came to the unit and took him down to the floor.

He was held face down on the floor for at least five minutes with enough of the aides' body weight on his back that he stopped breathing and died.

The US Court of Appeals for the Sixth Circuit ruled there were grounds for the family's wrongful death civil lawsuit and sent the case back to the Federal District Court for the Western District of Michigan for a jury trial.

The psychiatric nurse and the six aides will stand as individual defendants in a civil trial alleging assault and battery, abuse, neglect and violation of the deceased's civil and Constitutional rights.

A psychiatric nurse's decision to authorize take-down of a psychiatric patient is presumed to be correct.

The problem comes when the manner in which the restraint is carried out is not in accord with the best professional judgment.

Even though the psychiatric nurse herself did not participate hands-on in the patient take-down the nurse may still be liable under a supervisory-liability theory.

As on-the-spot supervisor of the restraint episode the nurse can be liable for the actions of the resident-care aides if the nurse as much as implicitly authorized, approved or knowingly acquiesced in her subordinates' improper actions.

The patient's safety and the safety of others are the only grounds for a nurse as a licensed professional responsible for patient-care decisions to decide to restrain a patient physically.

The psychiatric nurse is the one with the education, supervisory position and NAPPI training to make competent decisions and give competent directions.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
June 17, 2008

Nurse Can Be Liable as the Supervisor In Charge of the Take-Down

The facility used NAPPI training for its staff in proper techniques for hands-on restaint of agitated individuals. NAPPI is a private organization which markets staff training and other resources for patient behavioral management.

The aides were trained but apparently ignored their training never to restrain a patient face-down and never to put pressure on the patient's back because of the danger of suffocation.

They were still restraining the patient two or three minutes into the ordeal when the patient was, as they described it, "noticeably more calm," until five minutes into the ordeal when, "he wasn't resisting at all and looked like he had passed out."

The court faulted the psych nurse as the aides' supervisor and the aides themselves for actions which clearly went against the training they had received. **Lanman v. Hinson, __ F. 3d __, 2008 WL 2415926 (6th. Cir., June 17, 2008).**

Current CMS Regulations

The tragic events in this case occurred January 6, 2002.

Federal regulations in effect since January, 2008 now contain very detailed requirements governing use of seclusion and restraint for behavior management. These particular regulations are found under the general rubric of Medicare/ Medicaid conditions of participation.

We have placed the current CMS regulations found at 42 CFR § 482.13 on our website at http://www.nursinglaw.com/patientsrights.pdf.

Seclusion and restraint for behavior management are covered under § 482.13(f).

§ 482.13(f)(5) requires continual assessment, monitoring and reevaluation.

§ 482.13(f)(6) requires ongoing education and training of direct-care staff in proper and safe use of seclusion and restraint and techniques and alternative methods for situations traditionally handled through restraint and seclusion.

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

L & D: Nurses Denied Patient's Request For C-Section, $3,500,000 Settlement Awarded.

The parents' case against the hospital was settled during an out-of-court mediation session for a reported payment of $3,500,000 for the benefit of their profoundly developmentally delayed child, based on negligence by the hospital's nursing staff during the mother's delivery.

The settlement was reported with a stipulation that the names of the parents, physicians and the hospital would be kept confidential.

The mother, thirty years old at the time, entered the hospital pregnant with her first child and two weeks past her expected due-date.

Her pre-natal care, including non-stress tests eight and two days before admission, had been entirely normal. The first fetal monitor tracings in the hospital were also entirely normal.

The patient, however, was having extreme pain, charted by the labor and delivery nurse as 10/10. Six hours into her labor, still having intense pain, the mother requested a c-section. Her request was dismissed by a labor and delivery nurse on the basis that, "We do not do c-sections for first time pregnancies."

The nurse reportedly dismissed the patient's request without conferring with the certified nurse midwife or with the ob/gyn who were readily available on or near the unit. The husband asked again for a c-section several hours later.

The membranes ruptured spontaneously, with some meconium detected, soon after Pitocin was started. The monitor strips were still OK.

Late the next morning, thirty-six hours after admission, late decelerations were seen on the monitor. The nurse midwife notified the ob/gyn who called for an immediate c-section. The infant was delivered with Apgars of 1,5 and 5.

The labor and delivery nurses were also faulted for failing to appreciate the mother's risk factors, including elevated blood pressure, meconium seen at rupture of membranes and maternal fever, which should have prompted earlier evaluation by the ob/gyn.

Earlier evaluation by the ob/gyn, it was alleged, would have resulted in a more timely c-section delivery. **Confidential v. Confidential, 2008 WL 2020373 (Sup. Ct. Los Angeles Co., California, March 25, 2008).**

Death Of Patient: Court Rules Nurse Was Unfairly Denied The Right To Respond To The Charges.

The Oregon State Board of Nursing permanently revoked a registered nurse's license for the following alleged misconduct:

The patient had been having tarry stools and was up to the bathroom with twenty episodes of diarrhea during one p.m. shift. She was also clammy and was getting progressively weaker as the shift progressed. The nurse, however, never took vital signs until the very end of the shift.

The same patient on the same p.m. shift was reporting severe pain. The nurse removed a dose of morphine from the pharmacy cabinet and gave Tylenol instead because the family said the patient was not supposed to get narcotics, without verifying any of this with the patient's physician.

Files which document investigations of complaints to the State Board of Nursing are confidential and cannot be turned over to the public.

The nurse who is the subject of the investigation, however, is not considered just a member of the public.

The nurse or the nurse's legal representative cannot fairly defend the allegations without access to the Board's investigation file.

COURT OF APPEALS OF OREGON
May 28, 2008

The nurse twice gave Xanax for anxiety to this patient on the same evening in question, without any further assessment as to the source of the patient's anxiety and without conferring with the charge nurse or the physician.

When the nurse took the patient's BP at the end of the shift she allegedly documented it as "80/?" and left it at that. She allegedly told the husband the patient did not look good and was probably going to die soon.

The Court of Appeals of Oregon nevertheless overturned the license revocation, for the time being. The nurse's own rights were violated. Her attorney was improperly denied access to the Board's investigative file. **Shank v. Board of Nursing, __ P. 3d __, 2008 WL 2186172 (Or. App., May 28, 2008).**