LEGAL EAGLE EYE NEWSLETTER

July 2010 *For the Nursing Profession* Volume 18 Number 7

Cardiac Care: Nurse Failed To Report Status, Held Partially To Blame For Patient's Death.

The fifty year-old patient came to the E.R. early in the morning with chest pains and shortness of breath. He was examined, tested and treated in the E.R. and then admitted to the hospital around noon in stable condition.

An internist and a pulmonologist were called in to evaluate him. The internist believed there was a cardiac component to his illness but his primary diagnosis was pneumonia.

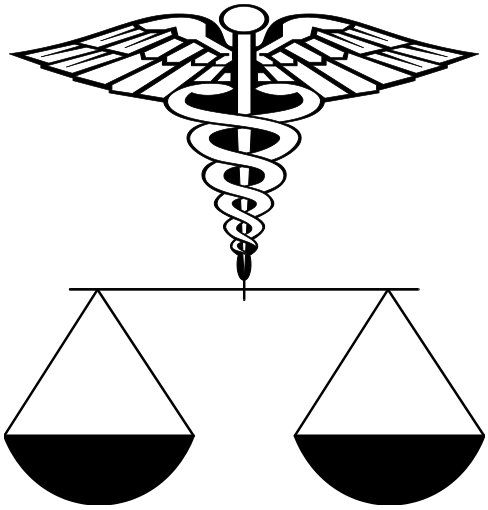
The pulmonologist, on the other hand, believed the primary problem was underlying mitral valve disease causing cardiac decompensation. The patient's own cardiologist detected mitral valve regurgitation and wanted his partner to do a transesophageal echocardiogram in the morning.

For the overnight the cardiologist put the patient on supplemental oxygen to help his breathing and Lasix to remove fluid from his lungs.

Night Nurse Failed to Report Patient's Deteriorating Condition

Two hours after the Lasix was started the patient's urine production did not increase as expected, indicating that the Lasix was not having the intended effect.

The patient's oxygen saturation dropped below 90%. The nurse switched the patient from a nasal cannula to a non-rebreathing mask, which would supply the maximum amount of oxygen possible without intubation, but that did not help.



A number of medical interventions should and would have been initiated promptly if a physician had been alerted to the patient's worsening condition.

These measure would have included intubation, a transesophageal echocardiogram, insertion of an intra-aortic pump and consultation with a cardiothoracic surgeon.

COURT OF APPEALS OF ARIZONA
May 27, 2010

The patient's cardiologist last saw the patient at 9:00 p.m. The nurse did not report the patient's deteriorating condition to anyone until 6:00 a.m. when the pulmonologist came in. The patient was significantly worse than the night before.

The internist came in at 8:20 a.m. and ordered the patient to the ICU. The cardiologist's partner came in and called in a cardiothoracic surgeon after the echocardiogram he did revealed a papillary muscle rupture and mitral valve problems.

By the time these measures were actually taken the next day the patient's oxygen saturation had declined drastically, he was in shock and his chances of survival, according to the family's medical expert, had fallen from over 90% to approximately 20%.

The patient died from complications of heart surgery that was performed that afternoon.

The Court of Appeals of Arizona upheld a jury verdict for the family which assigned liability for the patient's death 60% to the night nurse and 40% to the patient's cardiologist. **Salica v. Tucson Heart Hosp., __ P. 3d __, 2010 WL 2108492 (Ariz. App., May 27, 2010).**

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July 2010

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Post Surgical Care: Nurses Faulted, Failed To Read Signs And Report To Physician.

The patient was admitted to the hospital for surgical revision of an anterior cervical fusion.

After surgery the patient was taken to the post-anesthesia care unit, then transferred to the spine-institute floor at approximately 4:00 p.m.

At 7:00 p.m. he reported to his nurse that his pain had increased. At 7:30 p.m. and again at 8:00 p.m. he told a nurse he was having difficulty swallowing and pain in his nose.

At 8:30 p.m. he used his call light to call a CNA whom he told he was having trouble breathing and swallowing. The CNA told the charge nurse. She came and checked on him at 8:40 p.m. He was alert and his O_2 sat was normal, but he had noise in his lungs on exhalation and was coughing up phlegm. At 8:50 p.m. two nurses checked him again and paged respiratory therapy for a nebulizer treatment.

The nebulizer treatment was started at 9:20 p.m. The patient stopped breathing three minutes later. The respiratory therapist called a code. The patient was intubated at 9:59 p.m. and then sent to surgery to remove a hematoma that was blocking his airway. The surgery was too late to save him. He passed away six days later.

Nurses Were Trained To Look For Signs of Retropharyngeal Hematoma

The Court of Appeals of Minnesota noted for the record that the patient's nurses had been trained to look for possible signs of airway constriction following the type of surgery this patient had had.

The nurses misread the signs by assuming the problem was in the lungs, trachea or bronchi and deviated from the standard of care by calling for a nebulizer treatment. That decision should have been left to a physician. According to the Court, a physician would have recognized airway constriction was the basic problem and would have intubated or had someone intubate the patient promptly, which most likely would have saved his life. **Kuhne v. Allina Health System, 2010 WL 2363406 (Minn. App., June 15, 2010).**

The patient's family's medical expert's theory of malpractice is that the deceased's death was caused by the nurses' failure to alert a physician about the patient's signs and symptoms.

If a nurse had reported to the physician, the physician would have recognized the potential existence of a hematoma that was compromising the airway and would have ordered or performed an intubation to maintain oxygen flow.

The family's expert has never performed surgery to remove a hematoma following cervical disc surgery, but that is not the point.

He has familiarity, through his education, training and experience, with post-surgical intubation to open an airway obstructed by a hematoma.

The critical fact is, there would have been time to perform an intubation and save the patient's life if the patient's nurses had appreciated what was going on and reported in a timely fashion to a physician.

There is sufficient evidence for the family's case to go forward.

COURT OF APPEALS OF MINNESOTA
June 15, 2010

Suicide: Court Says Hospital's Nurses Complied With The Standard Of Care.

The patient phoned his psychotherapist and said that he had just taken a handful of Valium and needed to have his prescription renewed.

The therapist phoned the local police. The police went to the man's residence and took him to the hospital. The hospital's E.R. physician admitted him to the hospital's psychiatric service.

The patient told the psychiatric nurse who performed the initial assessment that he took the Valium because he needed to sleep. He expressly denied that he had tried to commit suicide or that he had any present intention of harming himself.

The psychiatrist put the patient on thirty-minute checks, meaning that a nurse was to enter the patient's room at least every thirty minutes, check on the patient's status and verify that no dangerous objects were present in the room.

Ten minutes after the previous room check the patient was found dead hanging from a bed sheet.

SUPREME COURT
ERIE COUNTY, NEW YORK
June 14, 2010

The Supreme Court, Erie County, New York ruled that the hospital was not at fault for the patient's death.

There was no evidence the hospital nurses failed to carry out their responsibilities under the plan of care prescribed by the attending psychiatrist. The patient's status was all right at each of the thirty-minute intervals. In fact, the Court pointed out, the patient was actually being checked more frequently than ordered. He was found dead just ten minutes after the previous time a nurse had entered the room.

The evidence was also inconclusive that the psychiatrist had mishandled his care of the patient. **Wulbrecht v. Jehle, __ N.Y.S.2d __, 2010 WL 2367350 (N.Y. App., June 14, 2010).**

Psychiatric Nursing: Nurse Faulted, Discharged Patient Without Full Mental Health Evaluation.

The daughter of the deceased sued the hospital after he mother was killed in a one-car rollover accident several hours after being discharged from the hospital against medical advice.

The patient had been referred to the hospital by another hospital's E.R. where she had gone to complain about non-existent sores around her eyes.

She revealed to the E.R. physician she had been off her medications for bipolar disorder for two weeks and had been driving around two states and in Canada for five days without sleeping trying to evade people who were after her.

She also revealed she had attempted suicide twice in the preceding month and was currently thinking of harming herself.

The E.R. physician had her admitted to the psychiatric service to get her started back on her meds. The physician ordered q 30 minute checks. The plan was to keep her for several days on a voluntary basis.

Several hours later, about 6:30 p.m. the patient's psych nurse spoke with the county mental health professional, but she had not seen the E.R. physician's evaluation which included her recent history and verbalizations of current suicidal ideation.

In the morning the nurse allowed the patient to leave the hospital against medical advice.

The hospital's psychiatric nurse spoke with the county mental health professional, but without first reviewing the E.R. doctor's admitting notes which revealed the true extent of the patient's gravely disabled condition and current suicidal ideation.

Nor did the nurse obtain a psychiatric consultation as she was told.

There was no documentation for the night shift that the nurse checked on her patient, who apparently was awake all night.

In the morning the nurse let the patient leave AMA even though the patient had not slept all night, had not re-started taking her meds and was still hallucinating.

The patient should have been held for an in-person interview by the mental health professional and kept for treatment.

COURT OF APPEALS OF WASHINGTON
May 24, 2010

The Court of Appeals of Washington reviewed the legal responsibilities of a psychiatric nurse under the circumstances of this case.

A psychiatric nurse has an independent professional responsibility to assess whether the patient has a mental disorder which presents an imminent likelihood of serious harm or whether the patient is gravely disabled. Either would be grounds for involuntary mental health commitment.

The nurse's assessment must include review of assessments done by other professionals, like the E.R. physician in this case who believed the patient was in acute need of inpatient psychiatric observation and care.

The psychiatric nurse must accurately communicate the patient's current condition to the designated mental health professional who has the authority to order an involuntary hold.

The mental health professional in this case decided not to order the patient held for treatment the evening before the morning she left the hospital, based in large part on incomplete information the patient's psych nurse relayed to him.

This patient had a well documented history of mental illness and had stopped taking her antipsychotic medications two weeks earlier. She was having auditory hallucinations and displayed active current paranoid and suicidal ideation when the nurse let her leave the hospital in the morning without taking steps to have her held involuntarily. **Poletti v. Overlake Hosp., 2010 WL 2028750 (Wash. App., May 24, 2010).**

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Labor & Delivery: Nurse Did Not Determine Presentation Before Cervidil, Pitocin.

The mother's water broke while she was attending a breastfeeding class at the hospital about two and one-half weeks before her expected due date.

She called her nurse midwife who told her to go home, wait until midnight and then go to the hospital's labor and delivery unit. Her contractions started as soon as she got home. As instructed, she waited until midnight and went to the hospital.

Labor & Delivery Nurse Did Not Determine Baby's Presentation

A labor and delivery nurse performed a vaginal exam but entered no documentation as to the baby's presentation.

The fetal monitor began showing fetal heart rate decelerations. The nurse paged the patient's nurse midwife, who told the nurse to give Cervidil to facilitate dilation of the cervix and Pitocin to induce labor.

The nurse midwife assumed the baby was in a normal vertex (head down) position because the labor and delivery nurse would have told her otherwise if the baby was in breech presentation.

Cervidil and Pitocin were started. The fetus began having heart rate decelerations which the nurse reported to the nurse midwife. A few hours later the nurse midwife decided to go to the hospital to do an ultrasound, which confirmed the breech presentation. The nurse midwife ordered a non-emergency cesarean.

During the next hour, thirty-three minutes went by with no detectable fetal heart rate. As the mother was on her way to the O.R. for the cesarean the nurse midwife reportedly rode with her on the gurney with her hand inside her vagina holding up the prolapsed umbilical cord.

The baby was born clinically dead but was resuscitated. Throughout her childhood she has shown profound developmental delays related to oxygen deprivation at birth.

The Court of Appeals of Georgia ruled there were grounds to extend the statute of limitations so that a lawsuit could go forward on behalf of the child. **Wilson v. Ob/Gyn of Atlanta, __ S.E. 2d __, 2010 WL 2029014 (Ga. App., May 21, 2010).**

This lawsuit alleging medical and nursing malpractice was filed almost seven years after the events in question.

The statute of limitations is two years for malpractice in Georgia. Because the case involves a minor, it comes under the statute of repose which extends the filing deadline to five years.

However, fraudulent concealment extends the time limit even further for filing a malpractice lawsuit.

There is evidence the hospital actively tried to conceal the facts from the parents at the time and then later from their attorney.

The parents were never told at the time that no one, not the labor and delivery nurse or the obstetrician, ever determined that the fetus was in breech position before starting the Cervidil and the Pitocin.

When their attorney requested the medical records, the umbilical blood gases, showing acidosis at the time of birth, were deleted from the copy of the chart that was provided.

The blood gas log from the lab eventually revealed that umbilical gases were done.

COURT OF APPEALS OF GEORGIA
May 21, 2010

Labor & Delivery: Monitor Strips Missing, Court Approves Jury Instruction On Spoliation.

The child is now showing cognitive deficits alleged to be related to oxygen deprivation around the time of birth.

His parents' lawsuit against the hospital where he was born pointed to the fact the nurses' progress notes mentioned decelerations of the fetal heart rate at various times during the mother's labor.

However, the fetal monitor strips are nowhere to be found.

Because the absence of the fetal monitor strips puts the parents at a significant disadvantage in proving their case, they are entitled to a special jury instruction at trial.

NEW YORK SUPREME COURT
APPELLATE DIVISION
June 15, 2010

The New York Supreme Court, Appellate Division, ruled that the jury will be given the following instruction:

The defendant hospital was required by state law to maintain the fetal monitor strips and failed to do so without adequate explanation.

Accordingly, when weighing the evidence, the jury may infer that the monitor strips would not have supported the hospital's position on the question whether there were fetal heart decelerations and/or variability and would not have contradicted the parents' experts' opinions that such decelerations and/or variability were present during the mother's labor.

The jury is permitted but is not required to draw an inference against the hospital and is permitted but not required to rule against the hospital on these key evidentiary points. **Coleman v. Putnam Hosp. Center, __ N.Y.S.2d __, 2010 WL 2404345 (N.Y. App., June 15, 2010).**

Discrimination: Minority Nurse Paid Less, EEOC Gets Settlement.

Soon after being hired at a rehab facility an African American staff nurse was asked by the executive director of the facility to accept the position of interim director of nursing when the current director of nursing gave notice she was retiring.

A minority nurse was promoted from staff nurse to interim director of nursing, but her salary was $10,000 less than the non-minority director of nursing who was retiring.

The assistant director, also a non-minority, made $2,000 more than she did.

UNITED STATES DISTRICT COURT
LOUISIANA
October 27, 2009

The minority nurse complained to management several months later when she learned about the salary discrepancies. She was fired the very next day.

She filed a charge of race discrimination with the US Equal Employment Opportunity Commission (EEOC).

The nurse's supervisor while she was a staff nurse took her side, telling investigators she interacted well with patients and family members, contrary to the reasons given by management for terminating her.

The EEOC obtained a settlement for the minority nurse. The facility paid her $22,500 to settle the wage disparity issue and agreed to provide favorable references to prospective future employers.

The facility also expressly agreed it would refrain from discriminating against other minority employees and would not retaliate against anyone who complained about discrimination.

The judge in the US District Court for the Western District of Louisiana issued a consent decree approving the settlement. **EEOC v. Bernice Nursing & Rehab, 2009 WL 6528659 (W.D. La., October 27, 2009).**

Discrimination: Nurse's Suit Over Husband's Medical Bills Thrown Out.

In 2008 the US Court of Appeals for the Seventh Circuit upheld a nurse's right to sue her employer for so-called "association discrimination."

The Court of Appeals ruled the hospital violated the nurse's rights under the US Americans With Disabilities Act as a person who had an association with a disabled person, assuming the nurse could prove the hospital terminated her because of the escalating costs of her husband's cancer treatments which were being paid by the hospital's employee medical benefit plan.

See *Association Discrimination: Nurse Fired Over Spouse's Medical Bills Has Right To Sue.* Legal Eagle Eye Newsletter for the Nursing Profession, (16)4, Apr. '08 p.5.

A groundbreaking court decision in 2004 was the first application of the concept of "association discrimination" to the scenario where an employee is fired because the employee's spouse has a chronic disability that is costing the employer's self-insured health plan significantly more than the employer wants to budget.

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
February 27, 2008

The case was sent back to the lower Federal court, the US District Court for the Central District of Illinois.

The District Court then ruled the hospital, in fact, had other, non-discriminatory reasons for firing the nurse.

The case went back again before the Seventh Circuit Court Appeals where the District Court's most recent ruling was affirmed on appeal. **Dewitt v. Proctor Hosp., 2010 WL 2465028 (7th Cir., June 16, 2010).**

Labor Law: Court Discusses Nurses' Union's Legal Duty Of Fair Representation.

A nurse sued her own union when she was terminated from her position after thirteen years at the hospital, allegedly due to the hospital's failure to provide her with reasonable accommodation under the US Americans With Disabilities Act.

Although the union did file a grievance on her behalf, her lawsuit claimed the union did not conduct an appropriate investigation, did not notify her to appear at the Step 1 and Step 2 grievance hearings and did not present evidence in her absence to corroborate that her termination violated the hospital's own internal human resources policies, the collective bargaining agreement and state and Federal law.

The nurse alleged that prior to her termination she notified her union she was facing termination and asked the union to file a grievance on her behalf.

UNITED STATES DISTRICT COURT
NEW YORK
May 11, 2010

The US District Court for the Northern District of New York ruled that the nurse's allegations against her union stated valid grounds for a lawsuit and that the lawsuit will go forward to determine if the allegations can be proven.

As exclusive bargaining representative, a nurses' labor union is required by law to serve the interests of all its members without hostility or discrimination, to exercise its discretion with complete good faith and honesty and to avoid arbitrary conduct, the Court pointed out.

The union's duty to provide fair representation is especially acute when a member has been terminated or is facing termination from employment. **Passante v. NY State Nurses Assn., 2010 WL 2425953 (N.D.N.Y., June 11, 2010).**

Norovirus: New Draft Guideline From CDC.

On June 16, 2010 the US Centers for Disease Control and Prevention (CDC) announced the availability of a new document *Draft Guideline for the Prevention and Control of Norovirus Gastroenteritis Outbreaks in Healthcare Settings.*

The document is for use by infection control staff, healthcare epidemiologists, healthcare administrators, nurses, other healthcare providers and persons responsible for developing, implementing and evaluating infection prevention and control programs for healthcare facilities across the continuum of care.

At this time the document is only intended to reflect current evidence-based recommendations and is not a formal statement of CDC policy or a new mandatory Federal regulation. The CDC will accept public comments until July 16, 2010.

The document is on our website at http://www.nursinglaw.com/norovirus.pdf.

FEDERAL REGISTER June 16, 2010
Pages 34146-34147

No Restraints: Family Obtains Settlement.

The elderly patient reportedly had a significant history of decannulating her tracheostomy collar and pulling on her trache and gastrostomy tubing.

The day before and earlier the day she died she was seen pulling on her tubing. Late in the evening she was found unresponsive with her trache tube, gastrostomy tube and pulse oximeter all disconnected.

The family's lawsuit filed in the Circuit Court, Kane County, Illinois claimed the nursing home's nurses should have restrained the patient on an emergency basis and then contacted the physician for orders for ongoing restraints.

The lawsuit settled for a payment of $325,000 to the patient's estate. **Rissinger v. Countryside Care Ctr., 2010 WL 2220236 (Cir. Ct. Kane Co., Illinois, April 8, 2010).**

Fall: Bed Alarm Not Plugged In.

The seventy-eight year old patient was admitted to the hospital for back pain related to spinal stenosis.

He was identified as a fall risk on admission based on a history of mental confusion and unsteady gait.

The fall-care plan included ordering and installing a bed alarm. The bed alarm was installed but apparently was not plugged in or was not working on the night in question.

The patient got out of bed by himself in the middle of the night to use the restroom. The bed alarm did not go off. He fell and broke his hip.

His hip was repaired surgically, which meant three extra months in a rehab facility to heal fully and extra medical bills.

The hospital was criticized by the patient's nursing expert because the alarm was not working. It was also her opinion the patient should have been toileted more frequently so that he would not have had to get up on his own during the night.

The jury in the Circuit Court, Jefferson County, Kentucky awarded the patient $134,047. **Miller v. Caritas Hosp., 2010 WL 2079846 (Cir. Ct. Jefferson Co., Kentucky, March 18, 2010).**

Neonate Dies: Hospital Pays Settlement.

The newborn spent ninety minutes in neonatal intensive care for mild respiratory distress, then went to the regular newborn nursery. She was active, had a stable temp and a vigorous cry and nursed without any problems in the early evening.

Around midnight the baby stopped breathing. An aide was told to take the baby to the newborn intensive care unit, but for some reason she took her instead to the nursery's nursing station.

The baby sustained hypoxic brain injuries from which she died six months later. The parents settled their lawsuit filed in the Circuit Court, Winnebago County, Illinois for $1,100,000. **Webster v. Rockford Mem. Hosp., 2010 WL 2245043 (Cir. Ct. Rockford Co., Illinois, March 31, 2010).**

Overdose: Jury Awards $3,000,000 To Critically Ill Patient's Family.

The family's lawsuit reportedly conceded that death was imminent for the critically ill seventy-nine year old but was unnecessarily hastened by administration of a 20 mg dose of morphine.

The jury in the Superior Court, Dougherty County, Georgia apparently agreed with the family. The jury awarded a verdict in their favor in the amount of $3,000,000 against the physician who ordered it and the hospital whose nurse gave the morphine.

The patient was in the hospital for end stage COPD when she went into respiratory arrest and a code was called. The critical care pulmonologist was able to bag the patient and revive her.

Afterward the family's doctor had a candid discussion with the daughter about the patient's dire prognosis. That discussion resulted in a DNR order being placed in the chart.

The plan of care was for the family doctor just to keep the patient comfortable by ordering 2 mg of morphine prn.

Only minutes later the critical care pulmonologist overruled the family's doctor. He ordered the nurse to push 20 mg of morphine.

The patient was reportedly talking with her daughter and granddaughter as the morphine was being pushed. She stopped talking, closed her eyes, lost consciousness and died three and one-half hours later.

Hospital's Defense
Morphine Did Not Cause or Hasten Patient's Death

The jury apparently rejected the hospital's argument the patient would have expired sooner than three and one-half hours after receiving the morphine if it was the 20 mg of morphine which in fact caused her death, as opposed to the unstoppable progression of her terminal illness.

The case was further complicated by the fact the patient did not receive her scheduled breathing treatments the night before the morning she went into respiratory arrest. **Pruette v. Phoebe Putney Mem. Hosp., 2009 WL 6521670 (Sup. Ct. Dougherty Co., Georgia, November 18, 2009).**

Beta Strep: Patient Was Not Called Back For Positive Lab Results.

After several days of headaches, fever and body aches, the patient, a forty year-old fitness trainer who had recently gotten over a urinary tract infection, went to her personal physician's office.

Her physician, an internist, told her to go to the emergency room. At the emergency room blood was drawn for bacterial cultures. The patient was sent home the same day after the blood cultures were read as negative.

Group B Beta Strep
Found Two Days Later

Two days later the lab determined the patient's blood was positive for Group B Beta streptococcus.

The patient's lawsuit alleged the emergency room medical director and the emergency room quality control nurse were negligent for failing to see that the patient was contacted about her positive blood cultures and advised to return for follow up evaluation and treatment.

SUPERIOR COURT
PLYMOUTH COUNTY, MASSACHUSETTS
June 1, 2009

Without being contacted and told to do so the patient returned to the E.R. several days later because her symptoms were still as bad or getting worse.

The diagnosis was endocarditis. The patient had to stay in the hospital for two weeks with aortic regurgitation and heart valve disease.

She reportedly will require valve replacement surgery at some point in the future.

The patient's lawsuit filed in the Superior Court, Plymouth County, Massachusetts settled for $1,200,000. **Confidential v. Confidential, 2009 WL 6521690 (Sup. Ct. Plymouth Co., Massachusetts, June 1, 2009).**

Ventilator: No Nursing Charting Of Baseline Respiratory Status.

The patient had arrested in the hospital while awaiting surgery for a fractured hip suffered in a fall at home.

He spent almost three months in intensive care before being transferred to a nursing home, still on a ventilator. His medical diagnoses included COPD, respiratory insufficiency, hypertension, diabetes and sensation neuromuscular disease and he had a PEG tube.

On his eleventh day in the nursing home family members found him unresponsive and cold to the touch. He was pronounced dead.

The family sued the nursing home. Although his medical status was basically terminal on admission, the lawsuit alleged that negligence by the nursing home's nursing staff deprived the patient of some percentage chance of survival.

The family's medical expert, a specialist in pulmonary medicine and ventilator-patient care, testified the patient was in respiratory distress in the hours leading up to his death.

The charting by the nurses and therapy staff breached the standard of care. There was no charting of his baseline respiratory status which, by comparison, would have alerted them he was in acute distress.

COURT OF APPEAL OF LOUISIANA
June 16, 2010

The Court of Appeal of Louisiana ruled the family's medical expert's opinion was sufficient evidence for the family's case to go forward. **Hebert v. Plaquemine Caring, __ So. 3d __, 2010 WL 2430389 (La. App., June 16, 2010).**

Botox: Nurse Is Sued Over Complications.

At a seminar conducted by a registered nurse a physician decided to have a series of cosmetic Botox injections for glabellar lines in her face.

The nurse had received training from the manufacturer how to conduct the seminars and how to administer the injections.

After the nurse finished the injections the patient began to experience symptoms of botulism poisoning including muscle weakness, partial paralysis, respiratory problems, difficulty walking, speech and vision impairments and severe pain.

The patient's problems became so severe she had to resign from her position as medical director of a hospital and close her own private medical practice.

In five separate treatments the nurse injected 50 mg, more than twice the approved cosmetic dosage of 20 mg and injected the Botox into areas of the face for which it is not approved for use by the FDA.

DISTRICT COURT
OKLAHOMA COUNTY, OKLAHOMA
May 11, 2010

The patient sued the nurse and the manufacturer. However, the patient dismissed the nurse from the lawsuit before the case went to trial.

The jury in the District Court, Oklahoma County, Oklahoma awarded the patient $15,000,000 from the manufacturer.

The training the nurse received from the manufacturer before the seminars reportedly instructed her to tell prospective clients that the potential side effects were insignificant and transient.

The manufacturer also reportedly trained the nurse to inject more Botox than the approved dosages and to inject facial areas not approved by the FDA. **Helton v. Allergan, Inc., 2010 WL 2383923 (Dist. Ct. Oklahoma Co., Oklahoma, May 11, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Aide Sleeping On The Job: Arbitrator's Decision Thrown Out.

A CNA was fired from a long-term care facility for violating the facility's work rule against sleeping on the job.

She was assigned to "fire watch" on one of the facility's residential wings, that is, she was simply expected to remain at the nurses station awake and alert through the night shift.

The aide grieved her firing through her union. The arbitrator chosen to hear the case ordered her reinstated. The facility appealed the arbitrator's ruling in Federal Court.

The US District Court for the Eastern District of Michigan threw out the arbitrator's ruling and upheld the facility's right to fire the aide.

The arbitrator saw mitigating circumstances which he felt made firing too harsh a penalty. However, according to the Court, the collective bargaining agreement gave the facility complete authority to make work rules and to define grounds for termination and said nothing about mitigating circumstances. The arbitrator was in error substituting his own judgment as to what the rules should have been. **SEIU Healthcare v. St. Mary's, 2010 WL 2232218 (E.D. Mich., May 27, 2010).**

Sex Discrimination: Male Psych Aide's Case Not Proven.

A male psychiatric attendant at a state hospital filed suit for gender discrimination.

His lawsuit claimed, among other things, that he was often singled out on the basis of his gender to participate in incidents that required physical restraint of patients who had gotten physically out of control, work he described as physically demanding and dangerous.

The US District Court for the Southern District of Indiana found the evidence inconclusive that he was actually required to respond to such incidents more often than his female co-workers.

Physical Size vs. Gender

Even if his number was being called more frequently, the Court said, a patient-safety emergency involving physical restraint requires supervisors to make choices based on necessity.

The aide is 5' 10" tall and weighs 245 lbs. The Court said relying on him because of his stature, physical presence and physical strength was not necessarily gender-based and was permissible in an emergency. **Wilkerson v. Indiana Family and Social Services, 2010 WL 2091895 (S.D. Ind., May 25, 2010).**

Family Member Assaulted: Court Faults Hospital Nurses, Security Staff For Waiting To Take Action.

The mother was visiting her young daughter on the hospital's pediatric unit.

Another mother and the other mother's two friends were visiting the other young patient in the room. The other mother began cursing loudly at one of her companions, apparently her boyfriend, then began throwing her daughter's toys, her purse and other items around in the room.

The charge nurse came to the room to see what was going on. She told the first mother she could move her daughter to a different room. Then the charge nurse left.

The other mother's behavior continued for almost a half hour before a hospital security guard happened by, heard the disturbance and entered the room.

A hospital is not responsible for a sudden, unprovoked criminal act by one hospital patron against another, but that is not the case here.

The pediatric unit charge nurse and the security guard were aware of the other mother's behavior and knew or should have known it presented a threat of imminent harm to the first mother.

SUPREME COURT
KINGS COUNTY, NEW YORK
June 4, 2010

The security guard stood by doing nothing for several minutes until the other mother assaulted the first.

The Supreme Court, Kings County, New York ruled this was not a case of a sudden, unanticipated assault. According to the Court, the charge nurse, an agent of the hospital, was on notice that the other mother's bizarre and menacing behavior presented a threat of harm to the first mother.

The charge nurse should have taken action to protect the first mother from harm at the hands of the other mother.

The first mother was not expected to put her own safety ahead of her daughter's by leaving her alone in the room while the other mother was acting out. **Davis v. Brookdale Univ. Hosp., __ N.Y.S.2d __, 2010 WL 2305478 (N.Y. App., June 4, 2010).**