LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

July 2011 Volume 19 Number 7

Cell-Phone Photo Of Patient: Hospital Had Grounds To Fire Employee, Court Rules.

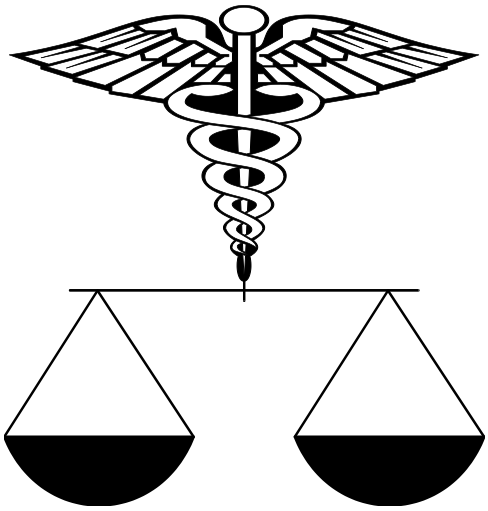
An emergency department patient technician was assigned to monitor a psych patient who had been placed in restraints in the E.R. due to intoxication and combative behavior.

The patient requested the technician remove his urinary catheter. While removing the catheter the tech became concerned over what he considered to be an excessive amount of tape that was used to secure the catheter tubing to the patient's upper thigh.

He believed this constituted mistreatment and he wanted to bring it to the attention of hospital management. He asked the charge nurse if he could use his personal cell phone to take a picture of the patient's leg and the tape. He was told, "just go ahead and deal with it," which he interpreted as permission to go ahead. He got verbal permission from the patient and took the picture.

After he showed the cell-phone picture to the emergency department nurse manager a meeting was scheduled with the nurse manager and a representative from hospital human resources.

Instead of hearing out his concerns over mistreatment of the patient they told him he was being terminated for unauthorized use of his personal cell phone and potentially bringing on liability against the hospital.



A healthcare provider can fire an employee for violating patient confidentiality while trying to alert a patient or others to a potential mistake.

Hospital policy was that employees absolutely were not to take cell-phone pictures of patients, but if necessary to use the hospital's Polaroid camera after the patient signed the hospital's consent form.

COURT OF APPEALS OF OHIO
May 13, 2011

The tech sued the hospital for wrongful termination, claiming the reasons given for his termination were pretexts for retaliation against him for trying to document and expose mistreatment of a patient.

The Court of Appeals of Ohio refused to see the tech's lawsuit against the hospital as a whistleblower situation and affirmed the lower court's dismissal of the case.

A hospital employee has no right to violate patient confidentiality while trying to alert a patient or others to something the employee believes is a case of legal liability against the hospital, the Court ruled.

The hospital was on solid legal ground, the Court went on, to have a policy which flatly outlawed employees from photographing patients with their personal cell phones, based on the hospital's strict legal obligation to protect patient's privacy rights.

If a patient needed to be photographed for treatment purposes the hospital's policy required use of the Polaroid camera kept in the E.R. and required the patient to sign the legal form for waiver of privacy rights provided by the hospital for that purpose before being photographed. **Strodtbeck v. Lake Hosp., 2011 WL 1944187 (Ohio App., May 13, 2011).**

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July 2011

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Skin Care, Skilled Nursing: Civil Monetary Penalties Upheld.

A skilled nursing facility was cited and assessed a civil monetary penalty for violations of three separate Federal regulations in the care of one particular resident, which was upheld by the US Court of Appeals for the Fifth Circuit.

Development, Progression Of Skin Lesions Is A Significant Change in Health Status

The resident developed two Stage II pressure ulcers, then two more two weeks later. A week after that one worsened to Stage III and a week later another worsened to Stage IV.

Facility staff did consult with the dietician to see if changing the resident's diet might help with the problems with her skin. The Court saw this as an indication there was a realization that there had been a significant change in her health status requiring a comprehensive re-assessment of her needs, which was never done.

No Documentation That Skin Lesions Were Unavoidable

The initial care plan on admission two years earlier called for lotion to the extremities twice daily, weekly skin assessments, turning and repositioning every two hours, an air mattress, whirlpool baths, nutritional supplements and use of a Hoyer lift for transfers. Basically none of this being done was documented in the chart.

A pressure sore can be considered unavoidable and not a violation of Federal regulations, despite the outcome, if routine preventive care was provided. However, according to the Court, routine care being in the care plan and routine care actually being done are two different things.

Assistance With Activities of Daily Living Call Bells Not Accessible

The Court also ruled that call bells not being accessible to this resident and several others was a violation of Federal regulations that mandate help with ADL's for residents who need help. The call bell has to be in reach, not on the floor or on the bed where the resident cannot reach it.

It is also a violation to provide a bottle of eye drops to a resident without assessing the resident's ability to self-administer. **Windsor Place v. US Dept. of Health & Human Svcs, 2011 WL 2437804 (5th Cir., June 17, 2011).**

Federal regulations for skilled nursing facilities require the facility to complete a comprehensive assessment of a resident after it is determined, or should have been determined, that there has been a significant change in the resident's physical or mental condition.

Significant change can mean a major decline in the resident's health status that will not normally resolve itself without further intervention or implementation of standard disease related clinical interventions, that has an impact on more than one area of the resident's health status and which requires interdisciplinary review or revision of the care plan.

Federal regulations require that a resident who enters the facility without pressure sores does not develop pressure sores unless the resident's clinical condition demonstrates that they were unavoidable.

Federal regulations require that a resident who is unable to carry out activities of daily living receive the personal services necessary to maintain good nutrition, grooming and personal and oral hygiene.

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT
June 17, 2011

Nurses' Duty To Monitor, Advocate: Court Sees Grounds For Suit.

The patient was in the nursing home for only two weeks before she was transferred to a hospital where she died in intensive care.

The family sued the nursing home for wrongful death due to nursing negligence.

The nursing home's lawyers filed papers with the Superior Court of Connecticut challenging the adequacy of the expert's opinion filed with the lawsuit, an expert's opinion being a mandatory prerequisite to filing such a lawsuit in Connecticut as in most US jurisdictions.

The nurses violated the nursing standard of care by failing to monitor, assess, collect data, advocate for the patient, obtain necessary labs in time, notify the physician of changes in the patient and recommend discharge to a hospital.

SUPERIOR COURT OF CONNECTICUT
May 24, 2011

The Court ruled the expert's report in fact did state grounds for a lawsuit for nursing negligence.

The Court focused on the fact that the patient's vital signs, lab values and medical diagnoses pointed to life-threatening abnormalities.

The problems documented in the nursing home chart included low BP of 95/31, extremely elevated INR, high BNP and BUN, acidosis, hyponatremia, low bicarbonate, lower and upper extremity edema, *C. difficile* with diarrhea and chronic renal failure, according to the Court.

The nurses had the responsibility to monitor these data, understand their significance, report to the attending physician and advocate for transfer of the patient to a hospital much sooner than was eventually done, the Court said. **Estate of Vissicchio v. CSC Enterprises, Inc., 2011 WL 2418684 (Conn. Super., May 24, 2011).**

Sexual Assault: Female Psych Patient's Case To Go Forward.

The Court of Appeals of Tennessee ruled that a female psychiatric patient's case could go forward against the facility where she allegedly was sexually assaulted by a male fellow patient.

According to the Court, male patients admitted to this facility were by the very fact of having been admitted to the facility known to be prone to unpredictable and potentially violent and assaultive behavior.

The facility's staff should have appreciated the vulnerability of a twenty year-old female patient suffering from acute psychosis and hallucinations.

The core technical legal issue was whether the patient's case could go forward without being backed by an expert's opinion as to the standard of care.

The Court ruled that a non-licensed non-professional staff person such as a security guard could have appreciated the danger to this patient and recognized the steps necessary to keep potentially assaultive male patients separated from her. Thus the legal issue was not professional malpractice, which requires expert testimony, but ordinary negligence, for which no expert is needed. **Brister v. HCA, 2011 WL 2395218 (Tenn. App., June 8, 2011).**

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Nursing Care Standards: Court Sees Immediate Jeopardy, OK's Civil Monetary Penalties.

The US Court of Appeals for the Eleventh Circuit upheld civil monetary penalties against a nursing facility for violations of Federal standards in the care of two separate patients.

The first patient was an eighty-three year-old woman who suffered from congestive heart failure, diabetes and obesity.

Failure to Follow Care Plan

Her care plan called for the use of a mechanical lift in all transfers. Nevertheless, two aides attempted to transfer her from her bed to her wheelchair without using the mechanical lift, in violation of her care plan. The patient was either dropped or lowered to the floor. It was not clear from the court record whether the patient was actually injured.

The Court ruled that this violation rose to the level of "immediate jeopardy" because members of the nursing home staff directly violated the care plan in the transfer of an elderly obese patient who suffered from serious medical conditions which made her unable to stand on her own even momentarily.

The second patient was an eighty-five year-old woman who suffered from congestive heart failure and dementia.

She managed to wiggle out of her wheelchair while two aides were standing by with her preparing to transfer her from the wheelchair. She fractured her wrist in the incident.

The patient was in a frail physical condition and had limited mobility and limited range of motion in her lower body, needed extensive assistance with transfers, had poor cognition and judgment and was known to fidget during care. Her diagnosis of osteoporosis made it extremely dangerous for her to fall.

The Court upheld a civil monetary penalty levied against the nursing facility, finding that this second violation also rose to the level of immediate jeopardy.

Failure to Provide Adequate Supervision to Prevent Accidents

The patient was not provided with adequate supervision to prevent accidents, a violation of the express language of Federal Medicare/Medicaid standards, the Court said.

That failure to provide supervision came in two forms. The aides who where with the patient when she wiggled out and fell should have been watching her more closely.

It also came to light that the patient was known to have the tendency to wiggle while in her wheelchair and had wiggled out of her chair on to the floor on previous occasions.

The patient's well-known tendency to wiggle in her wheelchair pointed to a need to address the issue of restraints for her own safety, but that was never done. **Golden Living Center v. US Dept. of Health & Human Svcs, 2011 WL 2308564 (11th Cir., June 10, 2011).**

Operating Room: Repositioning Seen As A Nursing Responsibility.

The patient was a 400 pound former professional football player with a muscular build who was positioned face-down on a Jackson table for a neurosurgical procedure that lasted more than ten hours, longer than expected.

The initial positioning and padding were done under directions from the neurosurgeon.

After the procedure the patient had pressure sores on his chest and brachial plexus atrophy palsy, a nerve injury which has rendered him permanently disabled with atrophy of his arms and little or no use of some of his fingers.

Seeing that the patient's pressure points are checked and the body repositioned every two to six hours to prevent pressure sores and to allow circulation was the responsibility of the nurses and the anesthesiologist.

COURT OF APPEALS OF TEXAS
June 9, 2011

The Court of Appeals of Texas upheld the jury's verdict of more than $900,000 for the patient which assigned blame 60% to the anesthesiologist and 40% to the nurses. The jury absolved the neurosurgeon from fault for the way the patient was positioned and padded at the start.

According to the Court, use of the table that was used in this face-down procedure causes pressure points on the chest and hips.

During a lengthy procedure it is wrong merely to allow pressure lesions to develop and try to treat them later. The nurses have to be aware that prolonged pressure can lead to compromised circulation and nerve damage and see that the patient is checked and repositioned. **Christus Health v. Harlien, 2011 WL 2394614 (Tex. App., June 9, 2011).**

Hyperkalemia vs. Hypokalemia: Nurse's Discharge Instructions Faulted, Hospital Pays Settlement.

The seventy-four year-old patient was taken to the emergency room with flu-like symptoms of fever, weakness and achiness. She also had recently fallen.

The triage nurse took her vital signs and started her on oxygen. The emergency room physician saw her and ordered x-rays and lab tests.

Everything was basically negative except for the fact that her potassium level was significantly depressed.

Nurse's Discharge Instructions Confused Hyperkalemia vs. Hypokalemia

The patient was discharged from the hospital by a registered nurse. The nurse explained the patient's diagnosis of hyperkalemia, excessive potassium.

Based on the nurse's faulty discharge instructions the patient discontinued her potassium supplements that she had been taking.

Two days later she was taken to another hospital's emergency department by ambulance by paramedics who were called when the family noticed mental status changes. Her potassium was even lower than it had been at the first hospital. She died less than two days later.

The family's wrongful death lawsuit filed in the Circuit Court, Oakland County, Michigan originally included allegations that the physicians at the first hospital failed to perform a complete physical examination to rule out pneumonia and/or a pulmonary embolism.

The allegations faulting the physicians, however, were eventually dropped, leaving only the allegation that the discharge nurse gave faulty discharge instructions based on 180° of confusion over the meaning of the patient's laboratory values. The hospital reportedly settled with the family for $100,000, part of which went to reimburse Medicare for her last expenses. **Walrath v. Smith, 2010 WL 6662906 (Cir. Ct. Oakland Co., Michigan, July 21, 2010).**

Catheterization: Patient Awarded Damages For Nurses' Negligence.

Right after laparoscopic bilateral hernia repair the surgeon gave orders for in-and-out urinary catheterization to drain urine from the bladder and to confirm there was no blood in the urine indicating the bladder might have been injured during the surgical procedure.

After the surgeon had left the operating room a registered nurse inserted a Foley with an inflatable retention bulb instead of an in-and-out catheter, then had another nurse inflate the bulb while it was still in the urethra.

The injury from the first insertion and inflation and injury from a subsequent insertion by a physician sideways through the tear in the urethra from the first insertion caused the patient to require catheterization by a urologist directly through the abdomen into the bladder.

The nurse did not follow the physician's order for in-and-out catheterization, using a Foley with an inflatable bulb instead.

Another nurse inflated the bulb while it was still in the urethra.

DISTRICT COURT
TARRANT COUNTY, TEXAS
April 15, 2011

The insurance company for the nurse who inflated the bulb settled for $200,000 prior to trial.

The jury in the District Court, Tarrant County, Texas then awarded additional damages against the hospital for the first nurse's negligence, which resulted in a total recovery by the patient of $720,000, for use of the wrong catheter and for miscommunication with the second nurse as to what the physician's orders actually were. **Steen v. USMD Hosp., 2011 WL 2489051 (Dist Ct. Tarrant Co., Texas, April 15, 2011).**

Misappropriation Of Funds: Aide's Termination Upheld By Court.

An aide working in a nursing home obtained written permission from one of the residents to handle her personal checkbook. The aide gave two notes signed by the patient to the charge nurse who placed them in the resident's chart.

The aide was fired and reported to the local police when the administrator learned she was handling the resident's affairs and confronted her and she was unable to account for the funds which were absent from the resident's checking account.

The aide sued for wrongful termination and malicious prosecution, claiming she was actually fired in retaliation for filing a worker's compensation case and for threatening to expose alleged violations of patient-care regulations. The Court of Appeals of Ohio upheld her termination.

Federal and state laws require nursing facilities to set up and enforce policies against abuse of residents and misappropriation of their funds, including a mandatory duty to report misappropriation to local law enforcement.

COURT OF APPEALS OF OHIO
June 24, 2011

Federal nursing home regulations require facilities to develop and implement policies to prevent mistreatment of residents and misappropriation of their property.

The nursing home's policy, which complied with Federal and state law, was that all resident funds were to be deposited with the nursing home administrator's office and employees were to refrain from handling resident's funds, even to the extent of not accepting funds even temporarily for immediate deposit with the front office. **Morris v. Dobbins Nursing Home, 2011 WL 2449008 (Ohio App., June 24, 2011).**

Self-Medication: Nurse's Firing Upheld By Court.

A nurse had a migraine headache when she arrived for work at the hospital shortly before her scheduled 3:00 p.m. start time.

She was told to rest. About an hour later he co-workers advised her to go home, but she stayed at the hospital and told her co-workers she believed she would be able to start working around 7:00 p.m.

At 5:00 p.m. she unexpectedly began breaking out in hives.

Nurse Used Her ID Card to Obtain Patient's Medication For Herself

To obtain a dose of Benadryl for herself the nurse went to the medication room, swiped her ID card and entered a patient's identification data. The equipment dispensed an IV dose of Benadryl, which was not what she wanted, so she disposed of the medication and entered in the patient's records that it had been wasted so that the patient would not be billed for it.

Then the nurse swiped her card again, entered the same patient's data and obtained a Benadryl pill which was what she wanted. The patient was eventually billed $4.25 for the medication.

Another nurse, surprised to see that the nurse had not gone home, looked into the medication room to check on what she was doing there. The computer screen on the medication dispensing unit seemed to indicate it had just been used. She told her supervisor what she saw.

The electronic record was checked and it was confirmed that the nurse in question had used her card and a patient's identification to obtain medication for her own use. She was fired a few days later.

The Court of Appeals of Wisconsin ruled the hospital had grounds to fire the nurse for misconduct.

The nurse's only argument in her defense was to raise the question why anyone would risk their job stealing something that would cost less than a dollar if purchased over the counter at retail. That argument ignored the hard evidence that she had, in fact, self-medicated on the job with a patient's medication, an offense serious enough to justify termination regardless of the dollar amount involved. **Grall v. State, 2011 WL 1991673 (Wis. App., May 24, 2011).**

Drug Screen: Nurse Fired For Falsifying Information.

A nurse who had been working through an agency applied for a position working directly for the hospital.

She gave a sample for a required drug screen and started working as a hospital employee before the results came back. When the results were delayed, indicating that something had been found, the nurse was confronted and disclosed she was on methadone as part of her treatment for chemical dependency.

She had stated on her employment application she was not taking any medications, a false statement, and she was fired.

The nurse was fired for falsifying information on her employment application.

COURT OF APPEALS OF OHIO
June 20, 2011

The majority of the judges on the Court of Appeals of Ohio who decided the case against the nurse were satisfied that the nurse was fired for falsifying information on her employment application.

One judge dissented from the majority opinion, insisting the nurse's lawsuit had raised legitimate questions about disability discrimination.

Chemical Dependency Is A Disability

Being a person in recovery for chemical dependency is considered a disability for purposes of disability discrimination law. Federal and state laws expressly protect a successfully rehabilitated drug abuser from discrimination.

This nurse had been working ten months at the hospital as an employee of a nursing agency taking care of critically ill patients in the ICU without any apparent problems. All the while she was strictly adhering to a monitored recovery program which included counseling and random drug tests. If the nurse was fired for her disability, revealed by disclosing her methadone use, that would have been illegal discrimination, the dissenting judge believed. **Wagner v. Regional Med. Ctr., 2011 WL 2448732 (Ohio App., June 20, 2011).**

Respiratory Arrest In ICU: Patient's Family Obtains Jury Verdict For Nursing Negligence.

The seventy-five year-old patient was in the hospital's intensive care unit recovering after a colon resection seven days earlier.

On admission she suffered from rectal bleeding, the reason for her hospitalization, and had a history of hypertension, but otherwise was in good health.

At 11:00 a.m. in the ICU she began to experience shortness of breath while sitting up in her chair. Her nurse encouraged her to take deep breaths and to use her incentive spirometer. Her O_2 sat was 96-98%.

The pulmonologist came in at 1:45 p.m. He saw that she had just vomited clear yellow material. His note expressed concern for aspiration if she vomited again. His orders included watching her respiratory status, giving an extra nebulizer treatment now, getting arterial blood gases if there was increased or decreased respiratory rate, decreased O_2 sat or change in mental status and npo except ice chips.

There was no nursing documentation of the physician's orders being carried out. At 3:00 p.m. the nurse noted a sustained respiratory rate of 47, although it was vague how long that went on.

At 5:25 p.m. the colorectal surgeon came to see the patient and reviewed her chart. From the information available from the chart that afternoon the patient seemed to be doing fine. He ordered a bolus of IV fluids.

At 6:00 p.m., shortly after the IV fluid bolus was given, the treating physician stopped by and found the patient basically unresponsive. She was alone in the room in bed with her head back and copious amounts of brownish fluid coming out of her mouth. He called a code.

The E.R. physician who responded to the code documented there was a large amount of yellowish/brown material in the patient's mouth as he attempted to insert the endotracheal tube. Efforts were already underway when he entered the room to suction the gastric material from the airway which was hindering efforts to ventilate her with a bag.

The patient could not be saved. She died from cardiac arrest from respiratory arrest secondary to aspiration.

The nursing standard of care was not carried out in regard to this patient.

The patient had a worsening respiratory condition, but there is no evidence from the chart that the physician's orders were carried out by the patient's nurse.

An extra nebulizer treatment was not given as ordered and arterial blood gases were not drawn when the elevated respiratory rate continued.

The nurse should have contacted the treating physician when the elevated respiratory rate continued.

The patient's nurse did encourage her to use her incentive spirometer.

However, there is no nursing documentation in the patient's chart that the nurse evaluated that intervention to see if it was effective, a vital step in the nursing process.

The nurse herself and the hospital's director of nursing testified that the nurse had received the hospital's general med/surg nursing orientation but had not oriented to the ICU, had little ICU experience and had not been specifically trained in respiratory assessment or respiratory care.

The nurse admitted she was not an ICU nurse.

COURT OF APPEAL OF LOUISIANA
June 15, 2011

The patient's adult children filed a lawsuit against the hospital. The jury awarded them damages for negligence by the nurse who cared for her that afternoon.

Two of the patient's daughters visited her that afternoon and later testified they told the nurse their mother was having great difficulty breathing, gasping like she was having an asthma attack and struggling to pull herself up to a sitting position. The nurse told them she needed to be told to use her spirometer and, other than that, there was not much she could do for her.

They also testified the call light in the room was not working.

Aspiration, Increased Respiration Tiring, Decreased Respiration Aspiration, Death

One of the physician expert witnesses testified it was unlikely the patient had a pulmonary embolism. Instead, once her respirations rose to 47, apparently after a small aspiration of stomach contents, because she was frail and elderly she easily tired from increased respiratory effort.

When the respiratory rate fell back to normal, the physician said, it meant that the patient had tired and was then at extreme risk for further aspiration, no longer being able to mount the effort to cough and clear the airways to the lungs.

There was no documentation that the nurse performed or had someone perform the nebulizer treatment that was ordered or obtained blood gases when the respiratory rate rose or reported the patient's change in status to a physician.

Nurse Was Not a Trained ICU Nurse

Much of the legally critical testimony in the case against the hospital centered on the patient's nurse's qualifications or lack thereof to work in the ICU.

The nurse herself stated that she was basically a med/surg nurse who floated to the ICU at times, but she did not consider herself an ICU nurse.

The director of nursing admitted the nurse was just assumed to have oriented to the ICU given the fact she sometimes worked there, but had actually never been trained in the care of respiratory patients in the intensive care setting. **Simmons v. Christus Schumpert, __ So. 3d __, 2011 WL 2348654 (La. App., June 15, 2011).**

Anticoagulant Therapy: Court Finds Grounds For Family's Lawsuit.

When she was admitted to the nursing home the patient was on Coumadin as a precaution against blood clots that could lead to embolism or stroke.

Her PT/INR values were found to be sub-therapeutic for a patient who required blood-thinning medication, so the Coumadin was increased.

When her PT/INR came back still below the desired range after a few weeks the Coumadin was upped and a second anticoagulant Lovenox was added. A PT/INR was ordered to be drawn two weeks after the medication increase went into effect.

The day before the PT/INR was scheduled the patient began vomiting blood and was taken to the hospital. Her PT/INR was beyond the therapeutic range. She died in the hospital that day from a gastrointestinal hemorrhage attributed to inadequate monitoring of her anticoagulant level.

The standard of care requires nurses in a nursing home to see that a patient on two anticoagulants has PT/INR monitored every one to three days so that the blood clotting mechanism is not allowed to be inhibited to the point that internal hemorrhage results.

COURT OF APPEALS OF TEXAS
June 16, 2011

The Court of Appeals of Texas ruled that the patient's family's nursing and internal medicine experts correctly stated the standard of care.

Even if the attending physician does not see the need for close, frequent PT/INR monitoring for a patient on significant doses of anticoagulant medications, the nurses should appreciate the need and should advocate for lab draws every one to three days, in the experts' opinions. **Pinnacle Health v. Calvin, 2011 WL 2420991 (Tex. App., June 16, 2011).**

E.R.: Triage Of Cardiac Patient Understated Urgency, Court Finds EMTALA Violation.

A hospital is liable for violating the US Emergency Medical Treatment and Active Labor Act (EMTALA) if the patient can show that the screening he or she received in the E.R. was not appropriate, that is, not the same as the standard screening that the hospital regularly provides to other patients presenting with substantially similar signs and symptoms.

"Appropriate" in the Act refers not to the outcome but to the hospital's standard screening procedures.

This patient had to wait almost two hours before even being seen by the E.R. physician, despite having been released from the hospital four days before after a pulmonary embolism and myocardial infarct.

Correctly following the hospital's chest-pain triage protocol would have produced an urgency-level classification of 1 or 2, not 3 as the patient was triaged.

Initial triage classification can be critical in the E.R. because it determines the aggressiveness and importance that will be given to further evaluation and treatment of the patient.

UNITED STATES DISTRICT COURT
PUERTO RICO
June 9, 2011

The forty-one year-old patient first came to the E.R. on February 17 with chest pain diagnosed as unstable angina.

She had cardiac catheterization and angioplasty that same day that corrected major blockages that were detected affecting the right coronary and circumflex arteries of the heart.

She was kept in the hospital until March 4 for follow up testing which included an echocardiogram and treatment which included an IV Heparin drip.

Patient Returned to E.R.
Had Significant Cardiac History

The patient returned to the same hospital's E.R. on March 8, four days after discharge, with new complaints of chest pain. She was given an urgency classification of 3 upon initial triage, meaning her case was not urgent. That was at 6:53 p.m.

She did not see a physician until 9:00 p.m. Another physician saw her at 11:30 p.m. but did not do an EKG. She continued having chest pain during the night but received no treatment except Vistaril for nausea. She died in the hospital less than twenty-four hours after she came in.

Chest-Pain Protocols Not Followed

The hospital's standard triage screening procedures called for a patient with chest pains and significant cardiac history to be classified as 1 or 2, that is, very urgent. A whole range of interventions were mandated for an urgent cardiac case including being seen immediately by a physician, an EKG and a cardiologist consult.

For purposes of a hospital's liability under the EMTALA, the issue is not the adequacy of the care given the patient but whether the initial medical screening given the particular patient was the same as the medical screening mandated by the hospital's protocols for other E.R. patients with the same signs, symptoms and history.

In this case, according to the US District Court for the District of Puerto Rico, the medical screening of this patient, starting with her urgency being incorrectly minimized upon initial triage, was sorely lacking. **Estate of Scherrer v. Hospital Espanol, 2011 WL 2360225 (D. Puerto Rico, June 9, 2011).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Horseplay In O.R.: Employee/Patient Has Right To Sue For Assault, Court Says.

A patient was admitted to the hospital for a tonsillectomy to be performed in the very same surgical department where he worked as a surgical tech.

As a joke, two of his co-workers, both registered nurses, painted his fingernails and toenails with pink nail polish, wrote "Barb was here" and "Kris was here" on each of his feet and wrapped his thumb with tape, while he was under anesthesia either right before or during the actual procedure.

Afterward the surgical tech sued the hospital and the co-workers involved in the incident for civil assault and intentional infliction of emotional distress.

The Court of Appeals of Texas ruled there were grounds for his lawsuit.

Assault in the Hospital
Is Not a Healthcare Liability Case

The Court rejected the argument that this was a healthcare malpractice case which required the patient to obtain expert testimony outlining a departure by the defendants from the standard of care or face dismissal of his lawsuit.

According to the Court, not every legal case which arises out of events in a health care setting is a health care liability case, even if the persons allegedly responsible were caregivers acting within the course of their employment in a healthcare facility when the events occurred.

The best analogy would be a sexual assault by a physician or other health care professional during the course of treatment. The professional standard of care for the treatment being rendered is not relevant and expert testimony is not needed for the victim to succeed in court.

Assault as the basis for a civil lawsuit is intentional physical contact which is known or reasonably should be known will be regarded by the victim as offensive or provocative.

The surgical tech alleged in his lawsuit that as a direct result of the intentional physical violation of his bodily integrity by his co-workers while he was unconscious he suffered humiliation and continued to feel extreme embarrassment afterward because of the negative impact that homophobic innuendo had on his work environment. **Drewery v. Adventist Health, __ S.W. 3d __, 2011 WL 1991763 (Tex. App., May 20, 2011).**

Arbitration: Patient Was Mentally Competent, Court Rules Arbitration Agreement Was Valid.

The seventy-four year-old patient had been living in an independent living facility where she fell and sustained an L1 vertebral fracture which required hospitalization followed by three weeks in the hospital's skilled nursing unit.

On admission to a nursing home from the skilled nursing unit there was concern she was suffering from a mental disorder even though she had never before been treated for mental illness.

An evaluation requested from a community mental health agency ruled out mental illness. Nursing notes referred to an ongoing urinary tract infection which seemed to account for the symptoms she was having.

On admission the patient signed an arbitration agreement along with thirty-seven other legal papers.

The patient claimed the arbitration agreement is unenforceable because she lacked the mental capacity to sign a contract when she signed it.

However, the mental status evaluation the facility requested when she was admitted indicates she did not suffer from major mental illness and that a more specialized placement was, therefore, unnecessary.

UNITED STATES DISTRICT COURT
KENTUCKY
June 20, 2011

Later the patient sued the nursing home for denial of treatment and improper care. The nursing home's first line of defense was to insist the court case be transferred to arbitration.

The US District Court for the Western District of Kentucky noted for the record an arbitration agreement is a contract and signed contracts are presumed valid. Convincing evidence is required to invalidate a signed contract.

The Court pointed directly to the admission mental health evaluation which was done not for legal protection but out of concern that the level of care available at the facility might not be adequate to meet the needs of an individual with mental illness. The evaluation disclosed no mental illness, mental impairment or cognitive deficit. **Abell v. Bardstown Medical, 2011 WL 2471210 (W.D. Ky., June 20, 2011).**