LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

June 2008 Volume 16 Number 6

One-Person vs. Two-Person Assists: Court Discusses The Nursing Standard Of Care.

The seventy-seven year-old male patient was in the hospital for treatment of a kidney stone.

He was taking pain meds for the kidney stone and various meds for his other medical issues which included renal failure, sepsis and atrial fibrillation.

His fall risk was classified as moderate to high.

The a.m. nurse had him get out of bed and sit in his chair. After eating breakfast he asked his nurse if he could use the bathroom. The nurse wanted him to use the bedpan, but he insisted on the bathroom and the nurse agreed.

The nurse helped him to the bathroom and showed him the safety rail and the call bell in the bathroom. When he asked for help to get up the nurse came and stood by him. He stood up but fell right back down. He was too heavy for the nurse to prop him up so she helped him gently to the floor. His ankle was fractured in the fall. The patient sued the hospital for nursing negligence.

The patient's lawsuit was dismissed by a lower court on the grounds the expert witness offered by the patient's lawyers did not correctly state the applicable nursing standard of care.

The Supreme Court of Delaware overruled and instructed the lower court to schedule the case for a jury trial.

It is a breach of the legal standard of care for only one person to assist a patient in standing, walking and using the bathroom when the patient has a high or moderate risk of falling, weighs 250 pounds and is dizzy or not alert.

The patient's level of alertness is the key. A solid nursing assessment is essential to avoid liability for a fall.

SUPREME COURT OF DELAWARE
May 15, 2008

Even when a patient is clearly too heavy for one person to lift it is not necessarily a breach of the standard of care for one person to assist with transferring, standing, ambulating or using the commode, the Delaware Supreme Court said.

The key is whether the patient has sufficiently stable alertness and safety awareness for one-person assistance.

In this case the factors pointing toward two-person assist included, first and foremost, the patient's size. The patient was also hypertensive, on medications for arrhythmia and atrial fibrillation and prone to abrupt drops in blood pressure upon rising from sitting to standing.

On the other hand, he had just transferred himself from bed to chair without any problem. He was able to talk coherently with his nurse about the issue of bathroom versus bedpan. He got up and walked to the bathroom all right. These facts could influence a jury to find that the nurse correctly assessed the patient with sufficient alertness and safety awareness to tolerate a one-person assist and to find that his fall was an accident that did not result from the nurse's negligence, the court said.

The case was sent back for a trial in which a jury will deliberate over the facts and reach a decision. **Simmons v. Bayhealth Medical Center, 2008 WL 2059891 (Del., May 15, 2008).**

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June 2008

New Subscriptions
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Fluid Overload: Hypoglycemic Neonate Seizes, Is Left With Neurological Injuries.

The newborn infant was transferred to the hospital's neonatal intensive care unit when hypoglycemia was first detected about three hours after he was born.

In intensive care a dextrose IV was started right away. Electrolytes were added to the dextrose nine hours later.

IV Therapy for Hypoglycemia
Peripheral Line

Infusion of IV fluid with dextrose and electrolytes continued the next day through a line inserted into a peripheral vein. The infant's blood sugar levels did not improve despite the fact he was getting 12.5% dextrose and the infusion rate was gradually being increased.

Signs of Fluid Overload

The next day, the second day on peripheral IV fluids, the infant's fluid intake was 370 cc but output was only 81 cc.

By evening the infant's sodium had fallen to 122. Another sodium level at 11:00 p.m. was also 122.

During the night the infant began to experience episodes of apnea and bradycardia and his oxygen saturation dropped even while he was on O_2.

Early in the morning the infant had a seizure and intraventricular hemorrhage.

The parents' lawsuit in the Supreme Court, Queens County, New York accused the physicians of negligence for using a peripheral line. A central line would have made possible infusion of a higher dextrose concentration. The nurse was faulted for failing to appreciate what was going on with fluid retention and low sodium levels reported by the lab.

The case settled during trial for $3,990,000. **Frias v. King, 2008 WL 1959944 (Sup. Ct. Queens Co., New York, March 6, 2008).**

Insulin Drip: IV Discontinued, Injections Not Started, Patient Arrests.

The fifty-three year-old female patient was in the hospital recovering from open heart surgery.

The patient was an insulin-dependent diabetic. Her physicians placed her on an IV insulin drip for five days after surgery. On the fifth day it was time to begin weaning her from the drip and get her back on her regular insulin injections.

Hospital Policy
Weaning Patients From Insulin Drip

According to the court record, the hospital had a standing policy for gradually weaning patients from insulin drips. Recognizing that the process can cause complications, frequent blood glucose monitoring throughout the process was expected to be done.

In this case the nurses abruptly discontinued the patient's IV drip instead of following the hospital's standing policy for gradually weaning the patient. The patient's blood sugar was not tested for more than seven hours after the drip was stopped.

After the patient was served and ate her dinner her insulin level naturally dropped. Having been a diabetic for many years, the patient herself knew her insulin was low and alerted her nurse at about 7:00 p.m. The nurse told the patient to go back to bed; she was not scheduled to have her blood sugar tested until 9:00 p.m.

That never happened. The patient went into cardiac arrest at 9:30 p.m. It took the code team thirty-six minutes to realize she had arrested because her potassium was high and she needed insulin. She was deprived of oxygen for forty minutes and is now profoundly disabled.

The jury in the Circuit Court, Duval County, Florida awarded the patient $8,800,000. **Gallagher v. Southern Baptist Hosp., 2008 WL 1808395 (Cir. Ct. Duval Co., Florida, March 22, 2008).**

Cardiac Care: Monitor Off For Thirty Minutes, Patient Arrests, Dies.

The patient was in the hospital recovering from a percutaneous angioplasty with stenting.

The patient's status was guarded. He was still having chest pain, chest tightness and nausea and was taking sublingual nitroglycerine.

The physician's plan was to keep him in the hospital, get him out of bed for ambulation and continue working on getting his potassium level back up to normal.

Nurse Gave Permission To
Take Off Cardiac Monitor
Nurse Left the Room

The patient asked his nurse if it was all right to take his cardiac monitor off while he went to the bathroom and got dressed.

The nurse told the patient it was all right only for the time it took him to use the bathroom.

However, the nurse then left the patient alone in his room for thirty minutes.

When the nurse returned the patient was lying on his bed. He was blue and was not breathing.

A code was called. The patient was revived and sent for a CT and then back to the cardiac catheterization lab.

Afterward all seemed well for a while. The patient lived eleven more days before succumbing to the effects of oxygen deprivation, that is, brain damage stemming from the interval from when his nurse left him alone until the code team revived him.

The widow sued the hospital in the Circuit Court, Macomb County, Michigan. The lawsuit pointed squarely at the nurse's negligence for allowing the patient to disconnect the cardiac monitor and then not staying with him or checking back right away with him to insure he had put it back on. The hospital paid a settlement of $1,250,000. **Sebastian v. Mount Clemens General Hosp., 2007 WL 5158008 (Cir. Ct. Macomb Co. Michigan, June 8, 2007).**

Medication Mix-Up: Nurses Continue Demerol IV, Post-Appendectomy Patient Seizes, Dies.

The thirty-three year-old male patient came to the hospital E.R. with abdominal pain. He was diagnosed with acute appendicitis and admitted for a routine appendectomy.

IV Demerol for post-operative pain was started in the post-anesthesia recovery unit. 100 mg was given the first hour in divided doses.

The patient was transferred to a med/surg unit with orders for IV Demerol 75 mg q 3-4 hours prn for pain.

The morning after surgery the physician who had performed the appendectomy ordered the patient started on a clear liquid diet.

Vicodin Ordered
IV Demerol Not Discontinued

The next day, two days after surgery, the same physician ordered Vicodin, an oral medication, two tablets q 4-6 hours prn for pain.

However, when he wrote the order for Vicodin the physician apparently did not cancel or modify the two-day-old order for prn IV Demerol.

At this point the Demerol the patient had received totaled 675 mg from the time he first came out of surgery.

The coroner's post-mortem lab tests established acute meperidine toxicity as the cause of death with hypertensive cardiovascular disease (enlarged heart) as a contributing factor.

Demerol (meperidine) is metabolized in the body into normeperidine, a chemical substance which tends to stay in the body and can build to toxic levels.

Normeperidine is a known neuro toxin which can cause a seizure.

Nurses at the hospital made the decision to continue the patient's IV Demerol for pain, even though the physician had written new orders for po Vicodin.

The surgeon at the hospital neglected to discontinue the Demerol expressly when he wrote the new order for po Vicodin.

SUPERIOR COURT, RIVERSIDE COUNTY
CALIFORNIA
January 17, 2008

Nurses Continued Giving IV Demerol

The nurse caring for the patient when the Vicodin order was written apparently believed that a patient on a clear liquid diet could not tolerate oral pain medication.

The patient was still having significant post-operative pain. The nurse made the decision to continue giving the IV Demerol prn instead of the Vicodin.

Nurses on successive shifts continued the IV Demerol prn for pain and did not give the Vicodin, sticking to the rationale that the patient sorely needed a narcotic for pain, while oral medication was not appropriate until the patient's diet had been advanced from clear liquids.

On the third day post-surgery the patient's p.m. nurse reported to the physician that the patient was still having severe abdominal pain. She gave the Vicodin.

When the p.m. nurse later tried to assess the Vicodin's efficacy by speaking with the patient he told her that the pills simply were not working. After speaking with the charge nurse the p.m. nurse gave still more IV Demerol.

The next afternoon the same p.m. nurse found the patient unresponsive and called a code. She told the code team he seemed to have been having a seizure. The fifty-minute code was not successful.

The family's lawsuit in the Superior Court, Riverside County, California reportedly settled for $3,500,000. **Confidential v. Confidential, 2008 WL 2020374 (Sup. Ct. Riverside Co., California, January 17, 2008).**

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Systemic Lupus Erythematosus: L & D Nurses, Physician Faulted For Mismanagement Of High-Risk Delivery.

The nineteen year-old obstetric patient had been diagnosed at age nine with systemic lupus erythematosus.

Her pregnancy was classified as high-risk. A perinatal medical group specializing in high-risk cases followed her pregnancy almost to term without complications.

She was admitted to the hospital for one day at near term for a flare-up of her lupus. Her rheumatologist agreed with her ob/gyn's plan to induce labor.

Four days later she came back to the hospital already in spontaneous labor. She was admitted to the labor and delivery unit and a monitor was started which showed reactive tracings with good variability.

At 1:00 a.m. the next morning she was dilated 8 cm, 90% effaced and at minus two station. An epidural was started for pain management. Finding the monitor tracings normally reactive, the labor and delivery nurse started Pitocin at 1:30 a.m.

An hour later the labor and delivery charge nurse ruptured the membranes and obtained clear liquid.

At 4:45 a.m. the on-call perinatologist came in and examined the patient. She was fully dilated so he instructed her to start pushing. The perinatologist saw some late decelerations on the monitor but was not concerned.

Nurse Saw Late Decelerations Stopped/Started Pitocin

A few minutes after the perinatologist left, the labor and delivery nurse lowered the Pitocin, then stopped it altogether after a few more minutes, being concerned about the late decelerations appearing on the fetal heart monitor.

An hour later, however, the nurse re-started the Pitocin for another forty-five minutes, then turned it off again.

At this point the facts are disputed. If the lawsuit had not settled but had gone to trial the nurse would have testified she did report to the perinatologist when she stopped the Pitocin both the first and second times.

The family's lawyers, on the other hand, were prepared to argued that the nurse believed the perinatologist was aware of the situation based on his exam at 4:45 a.m. The nurse saw no need to report to him again and did not report again before she left at the end of her night shift.

When the day nurse came on duty between 7:00 and 7:30 a.m. she was immediately concerned about the monitor strips but the night shift nurse told her the perinatologist knew about it and was in the process of deciding what to do.

The day-shift charge nurse finally did call the perinatologist at 8:00 a.m. He called for a cesarean. There was further delay of almost an hour getting the medical team together at the hospital for the procedure.

The infant was delivered by cesarean at 9:01 a.m. with poor Apgars and now has cerebral palsy.

High Risk Pregnancy

The labor and delivery nurses, the lawsuit alleged, should have been more vigilant with a high-risk patient. Systemic lupus erythematosis can result in a smaller than normal placenta which puts the fetus at risk for hypoxic labor complications. The nurses should have communicated more consistently to the patient's physician.

The hospital was faulted for the hour-long delay in starting the cesarean, albeit after more delay already attributable to the labor and delivery nurses and to the perinatologist in calling for the cesarean in the first place.

The $8,200,000 pre-trial settlement of the family's lawsuit filed in the Superior Court, Los Angeles County, California was reported on condition that the identities of the patient, physicians, nurses and hospital be kept confidential. **Confidential v. Confidential, 2008 WL 2020372 (Sup. Ct. Los Angeles Co., California, May 1, 2008).**

Post-Op Care: Failure To Monitor Leads To Amputation Of Pediatric Patient's Leg.

The fourteen year-old patient was taken to the hospital by ambulance with a fractured distal femur.

An orthopedist repaired the leg by closed reduction with percutaneous pinning. At midnight, in the recovery room, the patient began to complain to his nurse that his leg was numb and he could not move his toes. At 8:00 a.m. the nurse on duty noted that the toes were cool to the touch, there was no pulse in the foot and the patient was complaining of increased pain, but this information was reportedly not relayed to the orthopedist.

At 3:00 p.m. an arteriogram showed no blood flow below the knee. No vascular surgeon was available at the hospital so the leg had to be amputated and was amputated some three hours later.

Nursing Negligence

The family's lawyer brought in an outside nursing expert to testify that the hospital's nurses failed to monitor the patient competently, failed to understand the significance of the ominous signs they were seeing and failed to report to the orthopedic surgeon in time to save the patient's leg from having to be amputated.

Medical Negligence

The family's lawyer also brought in an outside orthopedist to testify that the treating orthopedist failed to discern and deal with the fact the popliteal artery was apparently damaged in the trauma that caused the fracture.

The jury in the Superior Court, Dougherty County, Georgia awarded the young man $24,529,286 split 90% from the hospital, 3% from the orthopedist and 7% from his medical practice group. **Harris v. Sumpter Regional Hosp., 2008 WL 1808397 (Sup. Ct. Dougherty Co., Georgia, March 10, 2008).**

Flash Sterilization: Patient Burned, Jury Blames The Nurses, Not The Surgeon.

According to the record from the Circuit Court, Monroe County, Indiana, the hospital only had one O'Connor-O'Sullivan retractor and it had been used earlier in the day on a procedure with a different patient.

The retractor was needed for the abdominal hysterectomy the obstetrician was starting, so the nursing staff were asked to clean it and then flash sterilize it in the autoclave in the operating room.

It was handed to the surgeon still hot from the autoclave. The surgeon laid it on the abdomen as the area was being prepped. The patient awoke with a second-degree burn in addition to her surgical scar.

The surgeon and her medical group were dismissed from the case on summary judgment.

Cooling of Surgical Instruments
Perioperative Nursing Responsibility

When the case went to trial against the hospital the jury heard expert testimony to the effect that responsibility lies with the perioperative nursing staff for ensuring that an instrument newly flash-sterilized is appropriately cooled before being handed to the surgeon.

The jury apparently believed the expert's testimony and gave the patient a verdict of $5,000.

The patient had additional expert testimony that repair of the scar will cost $8,000 to $10,000, not to mention the pain and suffering from the original injury and additional down-time for the revision surgery.

The patient's lawyers petitioned the court to deem the jury's verdict inadequate and to increase the damages to be awarded to the patient accordingly, but the court refused. **Allen v. Bloomington Hosp., 2007 WL 5145137 (Cir. Ct. Monroe Co., Indiana, September 18, 2007).**

Intubation: Dentures Not Removed, Jury Faults Nurses, Physicians.

The fifty-five year-old patient came to the emergency room with breathing problems. She was admitted to the hospital's intensive care unit.

The physician neglected to remove the patient's partial denture before intubating her in the ICU. The patient was weaned from the respirator after one week and was able to breathe on her own.

With hindsight it is now known that the processes of intubation and extubation apparently caused the denture to become lodged in the patient's posterior pharynx.

While temporarily off the respirator the denture in the airway caused continued internal bleeding, aspiration of fluid into the patient's lungs and a collapsed lung. A second intubation was necessary

The second intubation was performed with the denture still in the airway. The patient continued to deteriorate and soon died from shock.

Family's Lawsuit Faults
Medical, Nursing Care

The family's lawsuit alleged it was below the standard of care for the patient's nurses and physicians not to check the patient's mouth before intubating her. The nurses reportedly tried to claim the family had told them that the patient had left her denture at home, testimony that did not seem to make sense.

The lawsuit further faulted the nurses for failing to follow up with the bleeding they observed after the second intubation, an abnormal sign that something was seriously wrong which demanded immediate medical attention.

The jury in the Superior Court, Lake County, Indiana awarded the family $938,800 from the hospital in addition to monies the physicians had already paid to settle out of court. **Creviston v. St. Mary Medical Center, 2007 WL 5171070 (Sup. Ct. Lake Co., Indiana, November 30, 2007).**

Passy Muir Speaking Valve: Device Inserted Negligently By Nurse, Family Sues For Wrongful Death.

The patient went to the emergency room with shortness of breath and was sent home but returned the next day and was admitted to the intensive care unit.

After three days on a respirator the medical staff ordered a speech-pathology consult. The speech pathologist determined the patient was a candidate for a Passy Muir Speaking Valve, a device which makes it possible for an intubated patient on a respirator to communicate verbally.

Passy Muir Speaking Valve
Left at Bedside
Installed By Nurse

The patient was moved from the ICU to the telemetry unit.

A Passy Muir Speaking Valve was left at the patient's bedside, apparently to be put in place by the speech therapist.

A telemetry-unit staff nurse unfamiliar with the device went ahead and installed it. The nurse apparently did not know that the tracheostomy tube cuff has to be deflated and did not deflate it.

The patient suffocated and died.

The family's lawsuit pointed out that the device requires a physician's order, has to be inserted by a trained person, requires prior competent assessment of the intubated patient's ability to tolerate cuff deflation and actual cuff deflation at the time of installation. Further, after the device is in place there must be close monitoring by the bedside nursing staff and by personnel monitoring telemetry at the remote station.

The lawsuit filed in the Circuit Court, Macomb County, Michigan resulted in a $975,000 settlement for the family. **Skikiewicz v. Mount Clemens General Hosp., 2007 WL 5157903 (Cir. Ct. Macomb Co., Michigan, November 6, 2007).**

Labor Practices: "RNs Demand Safe Staffing" Buttons May Be Worn On Campus, Court Says.

During negotiations for a new collective bargaining agreement to cover the hospital's RN's, nurses began wearing buttons saying, "Together Everyone Achieves More," "Staffing Crisis – Nursing Shortage – Medical Errors – Real Solutions," and "RNs Demand Safe Staffing."

The hospital banned wearing of the last button in any area of the campus where nurses might encounter patients or family members.

Unfair Labor Practice Ban Extended Beyond Direct Patient-Care Areas

The US Court of Appeals for the Ninth Circuit ruled the hospital committed an unfair labor practice because the button ban extended to non-patient-care areas of the campus as well as direct-patient-care areas.

The court expressly discounted testimony from the hospital's vice president of human relations that several nurse managers had voiced their concerns that the button could have a negative impact on patients and family members.

The court said the testimony was speculative as to any real adverse impact of the nurses' buttons if worn by nurses only in non-patient-care areas.

Patient Safety is Legitimate Concern In Nurses' Union Negotiations

Recent US private-sector unfair labor practices cases have established that the effects of hospital nurse-staffing policies on the quality of patient care are legitimate concerns for the hospital's nurses.

Nurses and their representatives are entitled to express their concerns about nurse-patient ratios and mandatory overtime policies in appropriate locations on their employers' campuses in the context of union organizing and collective bargaining.

A ban on a particular message's expression everywhere on campus requires convincing proof that the time, place and manner of the message does in fact disturb patients or their families. **Wash. State Nurses Assn. v. NLRB, __ F. 3d __, 2008 WL 2096970 (9th Cir., May 20, 2008).**

The US National Labor Relations Act makes it an unfair labor practice for a private-sector employer to interfere with, restrain or coerce employees in the exercise of their rights.

Employees' rights in this context include the right to self-organization, to form, join or assist labor organizations, to bargain collectively through representatives of their own choosing and to engage in other concerted activities for the purpose of collective bargaining or other mutual aid or protection.

The National Labor Relations Board has recognized in general terms that union members have a protected right to wear union insignia in the workplace.

In healthcare the employer nevertheless can ban wearing of union insignia in direct-patient-care areas.

However, a restriction on employees wearing union insignia in other areas of the healthcare campus, for example, the cafeteria, gift shop and first-floor lobby, will most likely be ruled an unfair labor practice.

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT
May 20, 2008

Whistleblower: Terminated Staffer Gets Settlement.

A convalescent hospital's director of staff development complained to the director of nursing that a new hire did not have a valid nursing license or a social security number. That would make it unlawful for the hospital to hire her. The nurse was hired anyway but quickly terminated.

The staff development director also complained that it was highly unsanitary to send direct patient-care CNA's out to push garbage dumpsters from the rear to the front of the hospital. Three days later she was fired for alleged negative comments about the facility's new management.

Her wrongful termination lawsuit in the Superior Court, Alameda County, California was settled for $115,000. **Salonga v. D&R RCH Corp., 2008 WL 2101429 (Sup. Ct. Alameda Co., California, February 8, 2008).**

Whistleblower: Lawsuit Dismissed.

A nurse manager sued her former employer under the state's whistleblower law alleging she was fired in retaliation for her complaints to management.

Her complaints to management were that surgical instruments were not being sterilized correctly for the operating room and, further, that operating-room nursing staff were being discouraged from reporting the situation.

The New York Supreme Court, Appellate Division, ruled that the nurse manager had to point to a specific law or regulation and prove exactly how her former employer was violating it. Even a reasonable belief that possible violations of the law might have been occurring is not enough to qualify as a whistleblower. **Berde v. North Shore, __ N.Y.S.2d __, 2008 WL 1748333 (N. Y. App., April 15, 2008).**

Canavan Disease: Wrongful Birth Lawsuit Faults Nurse's Prenatal Screening.

A lawsuit filed in the Superior Court, Ocean County, New Jersey against a clinic nurse and three nurse-midwives by the parents of a child born with Canavan disease recently settled for $2,500,000.

The patient claimed the intake nurse at the clinic where she received her prenatal care did not ask the necessary questions about her and her husband's ethnic backgrounds to screen for Canavan disease, a genetic disorder that can affect descendants of Jews from Eastern Europe.

If both parents are suspected of carrying the gene for the disorder a relatively simple blood test can be done. If both parents are in fact carriers there is a one-fourth chance of their child being afflicted. With that information the parents can make their own informed choice how to proceed. **Alter v. Hale, 2008 WL 2039344 (Sup. Ct. Ocean Co., New Jersey, April 8, 2008).**

Spina Bifida: Patient Told Not To Take Prenatal Vitamins.

A judge of the US District Court for the Western District of Tennessee recently awarded more than $1,000,000 from the US government for the benefit of a child born with spina bifida.

The mother, then on active service in the US military, after relating her current plan to become pregnant to her doctor at a US military medical facility, was told she did not need prenatal vitamins, including folate, as she did not have an iron deficiency and could be harmed by taking supplements containing iron. **Brown v. US, 2008 WL 859148 (W.D. Tenn., March 31, 2008).**

Nurse As Beneficiary Of Patient's Will: Nurse Found Guilty Of Undue Influence, Will Is Invalid.

"Testator" is the legal term for a person who make a post-mortem distribution of property through a will.

A will is invalid if anything, such as undue influence, destroyed the testator's freedom of choice.

Undue influence means, in essence, that the wishes of another person were wrongfully substituted for the wishes of the testator.

Undue influence is presumed when a person listed as a beneficiary of a will occupied a confidential relationship with the testator, was not a natural object of the testator's bounty and took an active part in the planning, preparation and/or signing of the testator's will.

If the court sees the need to presume there was undue influence from the beneficiary's unusual and close relationship with the testator, the beneficiary has the very difficult legal burden of proof to establish that he or she did not exert undue influence.

When a will is declared invalid by a court, the deceased's property passes to the children or siblings as if there was no will.

SUPREME COURT OF GEORGIA
May 19, 2008

Members of the elderly patient's family hired a full-time live-in nurse to take care of him in his home after surgery for an aneurysm and a leg amputation.

The nurse was the sister of the patient's deceased wife's brother's wife.

Over time the nurse's sister and brother-in-law who had hired her began taking steps to keep the patient's daughter and granddaughters from visiting.

The nurse, her sister and her brother-in-law set up a meeting with the brother-in-law's attorney to have the patient sign a will leaving his only asset, his personal residence valued at $275,000, to the nurse.

Confidential Relationship
Nurse and Patient
Presumption of Undue Influence

According to record in the Supreme Court of Georgia, the nurse took care of all of the patient's personal and medical needs. The elderly amputee depended on his nurse for bathing, grooming, feeding, cooking, housekeeping, arranging medical appointments and transporting him.

The patient apparently believed his daughter and her family did not care to communicate with him and planned to put him in a nursing home. This impression was created in the patient's mind by the fact the nurse and her sister and brother-in-law were screening his phone calls, reading and throwing out his mail and physically reventing the granddaughters from visiting.

After he died his daughter contested the will. The court ruled the deceased and his nurse had a confidential relationship, that is, the nurse had been able to exert controlling influence over the wishes, conduct and interests of the patient.

The court ruled the nurse had to prove that she did not exert undue unfluence. She failed to meet that very difficult legal burden of proof, that is, the jury found the will invalid for undue influence. The deceased's home passed to his daughter as if he had no will. **Bean v. Wilson, __ S.E. 2d __, 2008 WL 2077911 (Ga., May 19, 2008).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Arbitration: Nephew Had No Legal Authority To Sign, Agreement Thrown Out.

Many healthcare facilities are turning to arbitration in an effort to stem litigation costs and to avoid large civil jury verdicts.

An arbitration case is heard out of court by a single arbitrator or panel of arbitrators, usually attorneys who practice in the particular field of law, who hand down a decision which cannot be appealed in court except in rare circumstances.

Valid Arbitration Agreement Is Essential

Only if the patient or a proper surrogate decision-maker has agreed to arbitration will arbitration keep a patient's or deceased patient's family's claim for damages against a healthcare facility from going before a jury in civil court.

That means the patient must sign an arbitration agreement at the time of admission if the patient is a mentally competent adult, or a proper legal surrogate decision-maker must sign if the patient is an incompetent adult or a minor.

In a recent case the Supreme Court of Mississippi threw out the arbitration agreement signed by a now-deceased resident's nephew when he put her in a nursing home.

The family's wrongful death lawsuit will go before a jury in civil court. As yet there has been no court ruling on the underlying negligence claims they are making against the nursing home.

Legal Surrogate Decision-Maker Can Sign For an Incompetent Adult

First in line is the person the patient, while still mentally competent, had named in a durable power of attorney or living will. If there is no such person, the patient's spouse is next in line.

If there is no living spouse, an adult child is next in line, then a parent, then an adult brother or sister. If none of the above is available any adult will suffice who is close enough to the patient to be familiar with the patient's own wishes.

The nursing home had no way to prove that the nephew had any legal authority to sign for arbitration and thereby give up the right to jury trial on the resident's behalf. Nephews are not mentioned in the healthcare-surrogate decision-maker statute and he could not honestly say he knew his late aunt's views on arbitration. **Compere's Nursing Home, Inc. v. Estate of Farish, __ So. 2d __, 2008 WL 2139548 (Miss., May 22, 2008).**

Employee Complaints: Court Sees No Forced Resignation, Rules Nurse Quit Voluntarily.

A registered nurse worked for a community blood bank as the trainer for phlebotomists and apheresis techs for almost twenty years before she tendered her resignation and quit.

She had been complaining to her supervisor about working conditions and safety issues. The court record in the Superior Court of New Jersey, Appellate Division, did not go into the details except for the complaint which brought on her resignation. She was told to add three individuals to a training class of ten, making thirteen, a number which she felt was unsafe.

Several of her other complaints were pending before the center's quality assurance committee, of which she was a member, at the time she resigned rather than compromise safety issues.

The employee's failure to discuss her grievances with management because she feared retaliation is not justified.

She did not take reasonable steps to resolve her complaints prior to tendering her resignation.

Under the circumstances she quit voluntarily without good cause attributable to her employment.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
May 20, 2008

The state unemployment office at first approved her compensation on the grounds hers was a forced involuntary resignation. The Superior Court, Appellate Division, however, ruled she quit her job voluntarily.

The court pointed out the nurse did not follow through completely in an effort to work out her grievances. Nor did she ever inform her supervisor she was dissatisfied with the process by which her grievances were being handled. The nurse did not go over her supervisor's head to a corporate vice president or the CEO. The safety issues she had raised were passed in favor of her former employer by the myriad state and Federal agencies which regulate and inspect the facility. **Stroli v. Board of Review, 2008 WL 2122336 (N.J. App., May 20, 2008).**