LEGAL EAGLE EYE NEWSLETTER

June 2009 — *For the Nursing Profession* — Volume 17 Number 6

Psychiatric Nursing: Facility Followed The Standard Of Care, Patient's Suit Dismissed.

The patient in question was admitted to the hospital's psychiatric department for treatment of depression.

Another patient was admitted with agitation and paranoia for treatment of schizophrenia. Her pre-admission history included reports that she had been "picking fights with almost everyone around her."

The other patient became agitated and combative on the morning in question. She hit, kicked and shoved a staff member.

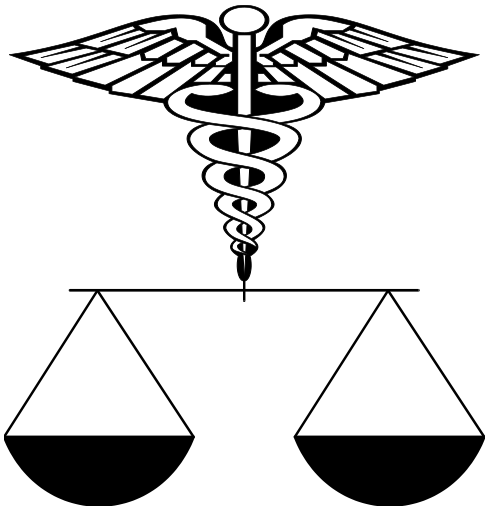
Following facility policy, the nurses on duty instructed the mental health technician who was accosted by the other patient to escort the other patient to her room for a fifteen-minute "time out" period.

During a "time out" the patient was required to remain in his or her own room, with the door unlocked, separated from other patients, basically just for the purpose of trying to calm down.

After fifteen minutes of "time out" staff were to check on the patient.

If the patient had calmed down the patient was allowed to leave his or her room and rejoin activities on the unit *ad lib* or remain in the room.

Only if the patient had not calmed down after fifteen minutes was the physician to be contacted to order more restrictive behavioral interventions.



Facility policy was for staff to place a combative patient in "time out" for 15 minutes.

If the patient was still combative after 15 minutes staff were to contact the physician for orders which could include seclusion in a locked room.

If the patient was no longer combative after 15 minutes, there was no basis to isolate the patient from others.

SUPREME COURT OF ALABAMA
May 22, 2009

A few minutes after a fifteen-minute check almost three hours after her "time out" ended the other patient attacked the patient in question, pulled her hair and smashed her head on the floor. She cried out and staff immediately came to help her.

The other patient was transferred to a different psych unit at the same hospital.

Patient's Lawsuit Dismissed

The Supreme Court of Alabama ruled the patient's lawsuit against the hospital should be dismissed.

Right before the assault there was no reason or basis for the other patient to have been more securely secluded to keep her away from other patients.

It was carefully documented in the other patient's chart that she was let out of "time out" after fifteen minutes, having fully de-escalated from her earlier agitated and combative state of mind.

It was also documented that staff had continued checking on the other patient every fifteen minutes for more than two hours and she was calm and quiet.

Facility's Policy/Procedure Accepted By the Court As the Legal Standard of Care

Hospital staff fulfilled their legal responsibilities by following facility policies which were in accord with the legal standard of care. 20/20 hindsight is not the standard in professional negligence cases. **Mosley v. Brookwood Services, Inc., 2009 WL 1425999 (Ala., May 22, 2009).**

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Respiratory Depression: Nurse Failed To Monitor, Chart Vitals While Giving Versed.

The forty year-old patient was diagnosed with probable acute renal failure and sepsis soon after arriving at the hospital around noon.

The physicians were not able to admit him to a med/surg unit right away and had to keep him in the emergency department.

At 8:30 p.m. he started showing signs of agitation and confusion.

By 11:20 p.m. his oxygen saturation on room air had fallen to 88% so the emergency room nurse tried to put him on O_2 via a nasal cannula. The patient, agitated and confused, kept pulling off the cannula and was pulling out his IV and so he was placed in a physical restraint.

Around 1:00 a.m. the physician decided to send him for an abdominal CT scan to see what was going on with his kidneys. The same E.R. nurse who had been taking care of him took him for his CT. The patient was unable to lie still, even though restrained, and so the CT was deferred for the time being. The patient was returned to the emergency department.

Another nurse gave him Ativan at 2:45 a.m. for agitation. The first nurse then gave three doses of Versed at ten-minute intervals between 3:30 and 3:50 a.m. in preparation for a second try at a CT and then transported him to the CT room.

At 4:12 a.m. the patient coded in the CT room and suffered a major brain injury from being asystolic for nine minutes. He is now in a long-term brain-injury facility.

There was no charting of any monitoring of the patient's condition, vital signs or O_2 sat for four hours before the code, despite the fact the patient had been showing signs of respiratory difficulty for hours and then received multiple doses of Versed.

The $6,000,000 settlement of the case filed in the Superior Court, San Francisco County, California was apportioned 85% against the nurses and 15% against the physicians. **Weatherspoon v. San Francisco, 2008 WL 5978919 (Sup. Ct. San Francisco Co., California, January 23, 2008).**

(Editor's Note: We first covered this case in August, 2008 and are now able to offer a more detailed version of the story.)

The hospital had protocols in effect for use of Versed in the emergency department.

Versed can cause serious life-threatening cardiorespiratory effects including loss of protective reflexes.

Close monitoring of level of consciousness, oxygen saturation and cardiac function is necessary so that changes in level of sedation and oxygenation can be detected before a patient suffers serious hypoxic injury to the brain and other vital organs.

The patient's nurse admitted he was required to monitor and chart vital signs and oxygen saturation on a continuous basis while his patient was on multiple doses of Versed and could offer no explanation for his failure to do so.

There was also no documentation to clarify whether the patient actually was on supplemental oxygen or was just breathing room air as his agitation and confusion progressed.

The emergency room nurse admitted to his colleagues he made serious mistakes in this patient's care.

SUPERIOR COURT
SAN FRANCISCO COUNTY, CALIFORNIA
January 23, 2008

Narcotics: Death Blamed On Nurses' Failure To Monitor.

The patient had a CT scan which traced his flank pain to a kidney stone and urine backed up in his right kidney.

The physicians began ordering significant doses of narcotics for pain management and IV saline for hydration to help him pass the stone.

The nurses' progress notes over his final eight hours stated the patient was "resting quietly."

The nurses were looking in on him regularly through the night but no vital signs or O_2 sats were obtained.

The patient was found unresponsive at 4:48 a.m. and was dead an hour later.

The autopsy tied the death to IV Demerol and Dilaudid.

UNITED STATES DISTRICT COURT
NEVADA
March 19, 2009

The deceased' family's lawsuit in the US District Court for the District of Nevada resulted in a verdict of $1,574,000.

The thrust of the family's lawsuit was that the patient's nurses failed to take vital signs or obtain oxygen saturations after the patient had received repeated large doses of analgesics with the tendency to depress respirations.

The O_2 sat reportedly dropped from 96% to 91% after the first 2 mg dose of IV Dilaudid, the patient having received 50 mg of Demerol IV push two hours earlier, eight hours before being found unresponsive.

The nurses were also faulted for failing to realize that a moderately obese patient can be more susceptible to respiratory depression, heightening the nurse's legal duty to do more than just look in on the patient. **Butts v. Universal Health Services, 2009 WL 1046343 (D. Nev., March 19, 2009).**

Supervised Visits: Patients' Privacy Rights.

Patients at a state-operated psychiatric facility filed a lawsuit in the US District Court for the Eastern District of New York challenging the facility's newly-adopted practice of supervising some of the patients' visitations.

The court ruled the patients' privacy rights were not being violated by the new practices in effect at this facility.

Only patients whose physician had ordered supervision had their visitations supervised.

The rationale for a physician ordering supervision for a particular patient was to clamp down on the smuggling of contraband into the institution, mainly tobacco which had been recently banned.

The guard stood by basically just to watch. The guard was within earshot of patients' conversations but patients were not required to speak loudly enough for their conversations to be heard. Nor did the guard make an effort to pry into patients' private affairs by trying to listen to what they were saying.

Supervised visitations were also monitored on video (no audio) at the nursing station and the video-only feed was taped. **Sparks v. Seltzer, __ F. Supp. 2d __, 2009 WL 1039886 (E.D. N.Y., April 20, 2009).**

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Stroke: Nurses Did Not Attend To Patient.

Two weeks after having a transient ischemic attack the patient was brought to the emergency room with left-sided weakness and slurred speech.

Blood was taken for lab work and the patient was classified as urgent.

However, for the first five hours that the patient spent in the emergency room the only thing reportedly done for her was O_2 being started.

The patient's own physician was not available. They physician who was covering for him was notified of the patient's presence in the hospital. He did not come to see the patient for almost thirteen hours.

The next morning the patient could not be roused and passed away later that day.

Jury Faults Only the Nurses

The family's lawsuit in the District Court for the Parish of East Baton Rouge, Louisiana resulted in a $500,000 verdict for the family which expressly faulted the hospital's nurses for the patient's death but did not fault either of the physicians.

Both sides conceded that the patient's situation was grave and her prognosis was poor when she arrived at the hospital.

However, the jury was allowed to consider and apparently accepted the argument that at least some small chance of survival beyond her present situation was compromised by the nurses' errors and omissions, that is, doing essentially nothing for the patient in her last hours. **Norwood v. Medina, 2009 WL 1181336 (Dist. Ct. East Baton Rouge Parish, Louisiana, January 8, 2009).**

Post Surgical Care: Nurses Waited To Report Drop In Blood Pressure.

Following a laparoscope-assisted vaginal hysterectomy the forty-four year-old patient was extubated, given an oxygen mask and administered morphine for pain.

Over the next few hours her blood pressure slowly dropped. Almost three hours after extubation her BP was 86/51 and significant distension of her abdomen could be seen.

However, her nurse reportedly decided since she was resting comfortably no action needed to be taken.

Fifteen minutes later a different nurse phoned an ob/gyn physician to report the low BP.

The ob/gyn did not come in for another two and one-half hours. By then the patient was drowsy and unresponsive. Her hemoglobin was very low, her clotting time was prolonged and her blood was found to be acidotic.

Exploratory surgery revealed two blood vessels still bleeding from the hysterectomy. They were repaired but the patient had already suffered irreversible brain damage.

The lawsuit filed in the Supreme Court, Queens County, New York settled for a reported $9,000,000. **Lazare v. Thenor-Louis, 2008 WL 6039306 (Sup. Ct. Queens Co., New York, October 2, 2008).**

Drug-Seeking Behavior: Patient Was Not Defamed By Chart Notes.

The patient came to the emergency room complaining of sinus headaches and stating that the Motrin she was taking was not relieving her pain.

Prescriptions for Flonase, Zantac and Percocet were given to her. She reportedly threw away the Flonase and Zantac prescriptions, kept the one for Percocet, blurted out in front of the nurse, "This is the only one I need," and abruptly left the hospital without allowing the nurse to finish her discharge instructions.

The nurse charted what happened.

Eight days later the patient showed up at the same facility's outpatient ENT clinic complaining of "life threatening" pain. The physician reviewed the chart entry from the recent ER visit and suggested she get some more Flonase and finish the rest of the Percocets she still should have had. The patient got mad and stormed out.

An hour later she was back in the emergency room complaining of a headache and stating that the only relief for the pain was Percocet. The physician, strongly suspecting drug-seeking behavior, decided not to prescribe any Percocet and noted in the chart his suspicions of drug-seeking as the reason for his decision.

The patient sued the facility, claiming that the nurse's and doctors' notations in her medical chart amounted to defamation of character. The Court of Appeals of Ohio ruled the case should be dismissed.

First and foremost, the chart notes concerning the patient's actual behavior were true. Truth is a complete defense to a legal action for defamation.

Secondly, publication of a defamatory statement is also a necessary legal element for defamation of character. Publication does not occur as long as the notations in a patient's medical chart, albeit disparaging, are kept confidential within the medical facility so that only facility employees or staff members are able to read what others have written. **Outlaw v. Werner, 2009 WL 1419496 (Ohio App., May 21, 2009).**

Theft: Nursing Home Employee Was Defamed By Her Former Employer's Comments.

A nursing home employee whose case we reported in February, 2005 and again in January, 2008 has finally obtained a definitive ruling from the Supreme Court of Connecticut upholding a $227,481 verdict in her favor.

A long-time resident of the facility had told the administrator and her son that she wanted the facility's admissions counselor to have her furniture after she passed away.

After she passed, as her family members were removing her personal property from the room, the admissions counselor took a couple of chairs home with her.

Later that day the administrator confronted her with the fact it was a violation of facility policy to accept any gratuity or gift of any sort from a patient or family.

The admissions counselor returned the items that day, but was terminated for theft of a resident's property.

People in the local small town came to believe that the admissions counselor was fired under heinous and loathsome circumstances, that is, for stealing a vulnerable person's property after the person was dead. In fact it was just a misunderstanding of the facility's zero-tolerance policy against gratuities and gifts.

The court endorsed the facility's policy which strictly forbade employee acceptance of any gift or gratuity from a resident or a resident's family.

The court determined at the same time, however, that the facility's administrator was guilty of defamation of character for circulating malicious gossip which grossly distorted the seriousness of what the admissions counselor had done and which gravely damaged her reputation in the local community. **Gambardella v. Apple Health Care, Inc., 291 Conn. 620, __ A. 2d __, (Conn., May 19, 2009).**

Unclaimed Body: Court Validates Family Members' Right To Sue.

A once-prominent New York playwright expired in a Manhattan welfare hotel.

The police called the paramedics who transported the deceased to a hospital where the body remained for 30 days before being donated to a community-college embalming program and then buried in the Department of Corrections' potters' field.

When the family went to visit him at the hotel and learned of his death they contacted the police and followed the trail of evidence to the hospital and the burial site.

They had the body exhumed for a more proper funeral and burial.

"Right of sepulcher" is the term the common law uses in granting to the next of kin the absolute right to the immediate possession of a deceased's body for preservation and burial.

Damages can be awarded to the next of kin against any person who unlawfully interferes or improperly handles the body.

NEW YORK SUPREME COURT
APPELLATE DIVISION
April 28, 2009

The New York Supreme Court, Appellate Division, validated the family's right to sue the hospital.

Hospital Procedures Were Not Followed

The hospital had policies and procedures for locating the next of kin.

However, there was no documentation of hospital procedures being followed. The sister was never contacted whose name and number were on file with the hotel desk clerk and relayed by the police to the hospital's nursing supervisor. **Melfi v. Mount Sinai Hosp., 877 N.Y.S.2d 300 (N.Y. App., April 28, 2009).**

Family And Medical Leave Act: Nurse's Rights Were Violated.

The nurse had medical restrictions after a shoulder injury from lifting a patient which she dealt with by getting herself a promotion to the position of Health Services Coordinator, a supervisory position which did not involve direct patient care.

Then the nurse fell at home and injured her foot. She was given disability leave until that problem resolved. However, when she was released to return to work she was offered only a staff position, not her former supervisory position.

After taking FMLA leave an employee is entitled to be restored to the same or an equivalent position.

The nurse's employer actively avoided designating her medical leave as FMLA leave despite the nurse's repeated requests for FMLA leave forms to fill out and submit to human resources.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
May 20, 2009

The US Court of Appeals for the Sixth Circuit ruled the nurse had rights under the US Family and Medical Leave Act (FMLA) which her employer violated.

An employee who is eligible for FMLA medical leave and who uses FMLA medical leave is entitled to be restored to the same or an equivalent position upon his or her return to duty.

The nurse's employer, however, labeled her absence as a disability leave under the facility's own disability-leave policy which did not require restoration to her former position, over the nurse's objections that she wanted instead to use the FMLA leave to which she was entitled. **Lafata v. Church of Christ Home, 2009 WL 1421104 (6th Cir., May 20, 2009).**

Public Health: Nurse's Inability To Drive Is Not A Disability.

To sue for disability discrimination under the US Americans With Disabilities Act (ADA) an employee must be able to prove:

1.The employee is disabled;

2.The employee is otherwise qualified to perform the essential functions of the job with or without reasonable accommodation; and

3.The employer took adverse action against the employee because of the disability or failed to make reasonable accommodation.

The first step is to define the term disability as it is used in the ADA.

A disability is a physical or mental impairment that substantially limits one or more major life activities.

The Federal courts have ruled that driving, in and of itself, is not a major life activity. Many Americans choose not to drive and do not consider the quality of their lives diminished.

The ability to work, in general terms, is not affected by the inability to drive. There is a wide range of jobs in the workforce, and in the nursing field, that do not require the ability to drive.

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
April 22, 2009

A public health nurse worked for the county as a family case manager. Her job required her to drive to clients' homes to evaluate infants' health and developmental issues.

The nurse had a motor vehicle accident off the job. Her physical injuries did not require emergency medical attention.

However, she had to start going to a psychiatrist after she started having panic attacks and difficulty sleeping.

Her psychiatrist diagnosed post-traumatic stress disorder from the accident. He approved a three-week medical leave of absence. Then he released the nurse to return to work, but with only minimal work-related driving because she could have a full-scale panic attack merely getting into a car.

The nurse's supervisor let her work part-time in an office near her home for a few weeks, but then insisted she resume her field duties fully, that is, if she wanted to keep her Public Health Nurse job classification.

She was also offered the alternative of applying for demotion to a clinic staff nurse position if that was more compatible with her medical restrictions.

The result of several rounds of union grievances was that the nurse could not indefinitely retain her Public Health Nurse position and only work part-time in the office as she did right after returning from her medical leave of absence.

She left her job and sued the county for disability discrimination under the US Americans With Disabilities Act (ADA).

No Disability Discrimination

The US Court of Appeals for the Seventh Circuit ruled the county did not commit disability discrimination.

An accommodation granted gratuitously to an employee to temporarily overlook an essential requirement of the employee's job does not have to be continued on a permanent basis.

The inability to drive is not a disability as contemplated by the ADA. There is a broad range of jobs available in the general workforce and in nursing for persons who for one reason or another cannot drive. **Winsley v. Cook County, 563 F. 3d 598 (7th Cir., April 22, 2009).**

Nurse As Expert Witness: Court Was Wrong To Exclude Her Testimony.

The patient developed pressure sores and then a sacral decubitus while in the ICU for complications which arose after bilateral knee-replacement surgery.

Although the skin condition eventually resolved the patient sued the hospital for nursing negligence.

The local district court dismissed the patient's lawsuit on the basis that the patient had no valid expert testimony to support his case, while the hospital did have valid expert testimony for its defense.

That is, the hospital's expert witness, a physician, was prepared to testify the patient's refusal as a Jehovah's witness to accept blood products led to anemia and hypovolemia which led to hypovolemic shock and renal failure which made breakdown of skin integrity virtually inevitable.

The patient's expert witness, a nurse, was prepared to testify there was no documentation of the patient being turned in the ICU even though the standard of care mandates assessment of skin integrity and turning immobile patients every two hours and documenting that it has been done.

It was legal error to disregard the nursing expert's testimony without a hearing and without any analysis.

COURT OF APPEAL OF LOUISIANA
May 8, 2009

The Court of Appeal of Louisiana ruled the local district court judge erred by categorically excluding the nursing expert's testimony simply on the grounds that she was a nurse and not a physician. The patient with his nursing expert is entitled to his day in court.

There has been no definitive ruling as yet that the hospital was, in fact, negligent in this patient's care. **Guardia v. Lakeview Regional Med. Ctr., 2009 WL 1270001 (La. App., May 8, 2009).**

Fall: Jury Finds No Nursing Negligence.

The patient, who has Meniere's Disease, came to the E.R. complaining of vomiting and dizziness.

She was placed on a stretcher within view of the nurses station. The stretcher had side rails but the rails were not raised. The patient was provided with a call light.

Moments later the patient was on the floor with a broken wrist.

The patient's lawsuit against the hospital in the Circuit Court, Fayette County, Kentucky resulted in a defense verdict in favor of the hospital.

The hospital defended on the basis that there was no reason or justification for raising the side rails or for using some other form of physical restraint.

The patient herself was guilty of negligence for apparently trying to get up to the restroom by herself without asking for help that was readily available from the nurses. **Henry v. St. Joseph Hosp., 2009 WL 1110292 (Cir. Ct. Fayette Co., Kentucky, March 4, 2009).**

Labor/Delivery: Nurses Did Not Advocate.

The patient was seen by the nurses in the outpatient maternity clinic the day before induction was scheduled at 42 weeks. The cervix was thick and closed and she was not having contractions.

The next day when she came in for induction they put on a monitor and got a fetal heartbeat, but it disappeared a few hours later. The baby was delivered stillborn by emergency cesarean.

The jury in the Circuit Court, Kenton County, Kentucky refused to fault the nurses for not advocating for an earlier cesarean, as opposed to induced vaginal delivery. The patient's morbid obesity rendered anything short of an emergency cesarean a very troublesome proposition. **Jameson v. Kirkwood, 2009 WL 1110283 (Cir. Ct. Kenton Co., Kentucky, February 6, 2009).**

Congestive Heart Failure: Verdict Faults Nursing Care.

The patient was receiving ongoing care from his cardiologist for rheumatic heart disease.

After coming to the emergency room for chest pressure, shortness of breath and dizziness he was admitted to a med/surg unit in the hospital for observation while an echocardiogram was obtained and the results interpreted by the physicians.

Over the next twelve hours his condition deteriorated. His oxygen saturation levels dropped and he needed supplemental oxygen. The physicians' diagnoses were unstable angina, congestive heart failure, pneumonia and acute coronary syndrome.

One of the physicians ordered Lasix to download the fluid causing the pulmonary edema and thereby improve oxygenation.

Nurse Did Not Report Lasix Was Not Working

Throughout the night, even with the Lasix, the patient's pulmonary edema did not resolve and his oxygen saturation levels did not improve. The patient's nurse, however, did not report this to the patient's physician.

In the morning he had to be taken to the ICU. Emergency surgery was done to replace a mitral valve. The surgery was a technical success but the patient soon had to be ventilated and remained on the ventilator until he died several weeks later.

The jury in the Superior Court, Pima County, Arizona awarded the family $1,000,000.

Sixty percent of the verdict was apportioned to the nurse's failure to monitor the patient for signs that would indicate whether or not the Lasix was having an effect on his pulmonary edema and the nurse's failure to report to the physicians that it was not working.

The physicians were faulted for the fact the patient was admitted at 4:00 a.m. but it was not until 8:35 p.m. that the results of the echocardiogram were available and nothing was done about the mitral valve problem until the next morning. **Salica v. Myer, 2009 WL 1348591 (Sup. Ct. Pima Co., Arizona, April 27, 2009).**

Transfer: Nurse Did Not Report Ob/Gyn Patient Showing Signs Of Abruption.

A very complicated labor and delivery case from the US District Court for the Northern District of Iowa produced a jury verdict of $1,710,000 for the parents of a stillborn child.

After she began having vaginal bleeding, abdominal pain and contractions at home the mother was taken to the emergency room at a rural community hospital.

The physician on duty got the ultrasound tech to perform an ultrasound, but had to send the images electronically to an on-call ob/gyn in Minnesota for interpretation. They decided it was best to have the mother transported to a hospital one-hundred miles away in Sioux Falls, SD which had far better obstetric capabilities.

A nurse from the rural community hospital was assigned to ride along with the mother.

During the trip the mother was reportedly having rapid contractions, profuse vaginal bleeding and severe abdominal pain while the fetal monitor in place was showing clear signs of fetal distress.

Nurse Failed to Report While Patient Was In Transit

The nurse, however, made to effort to contact a physician at the first hospital or at the hospital where they were going to report that the fetus was in distress because signs were there that the placenta had abrupted and/or the uterus had ruptured.

Had the nurse reported what was going on, the experts told the jury in court, the ambulance could have been diverted to one of several community hospitals along the way where an emergency cesarean could have been done which, more likely than not, would have saved the baby.

There were also allegations that the physician at the first hospital did not follow the letter of the Emergency Medical Treatment and Active Labor Act (EMTALA) before sending the patient to another facility. **Heimlicher v. Steele, __ F. Supp. 2d __, 2009 WL 1361164 (N.D., Iowa, May 14, 2009).**

Seizures: SNF Violated CMS Regulations, Civil Monetary Penalty Upheld By US Court.

Centers for Medicare and Medicaid Services regulations for skilled and long-term nursing care require:

The facility must develop and implement written policies and procedures that prohibit mistreatment, abuse and neglect of residents and misappropriation of resident property.

Simply maintaining documents in a file, without also implementing the policies contained therein and regulating staff actions to assure compliance, does not satisfy the regulation.

The facility must also immediately inform the resident, consult with the resident's physician and, if known, notify the resident's legal representative or an interested family member when there is a significant change in the resident's physical, mental, or psychosocial status.

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT
April 17, 2009

The fifty-four year-old patient was admitted to a skilled nursing facility with diagnoses of end-stage diabetes mellitus, depression, congestive heart failure, renal insufficiency, hypothyroidism and a history of stroke.

Patient's Care Plan / End of Life Care

The resident's care plan, among other things, called for staff to watch for shortness of breath, drowsiness, confusion, numbness or tingling, to monitor her blood pressure and to notify her physician of any signs or symptoms of a hypertensive crisis.

Her care plan also called for caregivers to watch for changes in cognitive function that might be indicative of a repeat stroke, and notify her physician.

Patient's Seizures

When the patient had her first seizure staff members tried to reach the on-call physician but were unable to get through. They called the hospice, but all the hospice did was have someone stop by the next day to look at her necrotic big toe.

After the next seizure two days later the on-call physician was not called for three hours and the resident was sent to the E.R. two and one-half hours after that.

Surveyors Issue Notice of Deficiency

The facility was cited for violations of the Federal regulations which apply to care of residents under Medicare in skilled nursing facilities and under Medicaid in long term nursing care.

The US Court of Appeals for the Tenth Circuit upheld the citations issued against the facility.

The facility was not guilty of or even cited for abuse or neglect. Nevertheless, the court pointed out, the facility still violated regulations which require implementation of written policies and procedures to prohibit neglect and abuse.

In a nutshell, the resident had a good solid care plan but the care plan was not followed. The resident was not monitored closely and changes in her health status were not reported to her physician as promptly as they should have been. **Cox Retirement Properties v. Johnson, 2009 WL 1028045 (10th Cir., April 17, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Cerebral Aneurysm: Lawsuit Faults E.R. Personnel.

The patient went to a retail optometry store to complain that she had been feeling something in her eye for three days. They sent her to the hospital E.R. The E.R. triage nurse checked the patient's visual acuity, finding 20/200 vision in that eye and 20/30 in the other.

The nurse had the patient seen by a second-year ophthalmology resident from the hospital's outpatient vision clinic. He carefully examined the structure of the affected eye, found nothing wrong and sent the patient home with eye drops.

The patient came back the next day and saw an ophthalmologist. He got a CT and sent the patient home with an appointment to come back and see a neurologist.

She collapsed and died at home from a ruptured cerebral aneurysm before the CT was read at the hospital. The jury in the Supreme Court, Kings County, New York awarded $2.15 million for negligence by the E.R. personnel who failed to bring in a neurologist right away. **Collazo v. NY Eye and Ear Infirmary, 2009 WL 1199357 (Sup. Ct. Kings Co. New York, March 18, 2009).**

Contraindicated Use: Lawsuit Faults Surgical Staff.

The patient developed partial paralysis as a complication of spinal surgery.

Her condition was traced to the surgeon's injection of methylene blue into her spine as a stain to locate the site of a spinal fluid leak, a contraindicated use of that particular substance.

A pharmaceutical vendor's people reportedly removed the vials from shipment boxes and stocked them in the surgery supply case, throwing away the package inserts in the process.

The jury in the Circuit Court, Miami-Dade County, Florida assigned 18% of the $38 million verdict to the hospital. Most of the blame for the patient's injury was assigned to the surgeon and the pharmaceutical vendor.

The partial verdict against the hospital was based on the argument that hospital surgical personnel have an independent duty to investigate, understand and communicate to the surgeon pertinent contraindications of substances used in the operating room. **Slavin v. Mount Sinai Med. Ctr., 2009 WL 1199242 (Cir. Ct. Miami-Dade Co. Florida, March 16, 2009).**

Sedated Patient Scalded In Shower: Court Finds Evidence Of Negligence By Obstetric Nurse.

The patient was admitted to the hospital for nausea and other problems associated with her pregnancy.

She had been a diabetic since childhood and had some degree of neuropathy in her lower extremities.

Her nurse gave her Phenergan and Reglan IV per her physician's orders. Either medication alone can cause drowsiness, even stupor when given together.

The nurse insisted the patient take a shower. She escorted her to the shower stall, put her on a shower chair with a back, turned on the water and placed the hand-held nozzle in the patient's hand. Then the nurse left her alone.

The patient fell asleep with scalding water running on her upper thigh until the nurse returned to check on her over an hour later.

The patient's nurse knew that the patient was diabetic and had neuropathy in her lower extremities.

That is, the patient sometimes could not feel heat or pain in her legs.

The patient's nurse also knew that the patient was on Phenergan and Reglan, having given her the meds herself, and knew that these meds can cause, and in this particular patient were causing drowsiness.

COURT OF APPEALS OF GEORGIA
May 5, 2009

The Court of Appeals of Georgia ruled there were grounds to sue.

The patient's lawsuit had been dismissed by the lower court on the grounds that the patient's nursing expert was not qualified to testify in a malpractice case.

The Court of Appeals pointed out that the patient's nursing expert was a licensed RN who had been working in obstetrics full time four of the previous five years and served as adjunct faculty at two nursing schools. She was qualified to testify as an expert.

Even without an expert opinion the nurse's negligence seemed clear.

The Court of Appeals also faulted the hospital for not installing a device to regulate the temperature of the water going to patients' showers. **Lee v. Phoebe Putney Mem. Hosp., __ S.E. 2d __, 2009 WL 1199450 (Ga. App., May 5, 2009).**