LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

June 2010 Volume 18 Number 6

Dysphagia, Choking, Death: Civil Monetary Penalty Upheld Against Nursing Facility.

The sixty year-old nursing home resident suffered from schizophrenia and dysphagia.

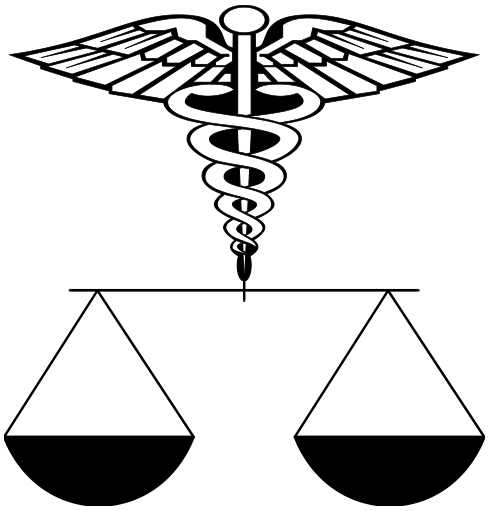
Her dysphagia was so severe that she could not safely consume any food or liquids due to the risk she could aspirate, that is, inhale foreign matter into her trachea and lungs, resulting in suffocation.

A percutaneous endoscopic gastrostomy (PEG) tube was inserted into her stomach through the wall of her abdomen. The PEG tube was to be the only permissible means for her to receive nutrition or hydration.

After insertion of the PEG tube she was returned to the nursing home with orders from the hospital that she was to be a strict npo patient. She was to receive nothing by mouth to eat or drink.

The resident was observed on at least eighteen occasions obtaining and ingesting food and liquids, according to the record in the US Court of Appeals for the Seventh Circuit. Presumably there were numerous other occasions which were not observed or recorded.

The resident was found dead on the floor of her bathroom. The first death certificate listed aspiration pneumonia as the cause of death. A physician changed it to schizophrenia and chronic obstructive lung disease after a lawsuit was filed by the family.



Federal regulations require a nursing facility to ensure that - The resident environment remains as free of accident hazards as possible; and Each resident receives adequate supervision and assistance to prevent accidents. The PEG tube itself and the hospital discharge orders signaled a serious risk if the resident consumed food or drink.

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
May 6, 2010

Staff had repeatedly instructed and reminded the resident she was not to take food or drink from other residents' meal trays. However, according to the Court, education, admonishment, correction and redirection are often not effective safety measures with a patient with cognitive or behavioral deficits like those suffered by this patient.

The resident needed very close supervision when outside her room during other residents' meal times.

The patient's roommate was also giving food to her. The patient should, at least, have had a roommate who did not eat her own meals in their room, or, better but more expensive, could have been placed in a room by herself.

The water faucet in the room was a known safety hazard. The patient was seen drinking from it. It should have been locked so that only staff could access the sink to perform ADL's but the patient herself could not turn the water on, the Court said.

Unlike a civil lawsuit for damages, imposition of a civil monetary penalty for violation of Federal standards does not require proof the violation was the actual cause of death, only that it presented a serious risk of harm. **Fal-Meridian, Inc. v. US Dept. of Health and Human Services, __ F.3d __, 2010 WL 1791366 (7th Cir., May 6, 2010).**

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Overdose: Family Members Can Sue If Cause Of Death Misrepresented By Caregivers.

The patient was in the hospital recovering after hip surgery.

She was given esmolol when her blood pressure and heart rate spiked. After getting the esmolol the patient went into cardiac arrest and died.

The physicians and nurses caring for the patient documented in her chart that she died from stress associated with surgery. The medical examiner did only a partial autopsy and then the released the body to the family for burial.

Then word began to circulate that the patient's caregivers were covering up the fact she really died from esmolol toxicity. When word got around to the medical examiner he placed a call which reached the daughter during the funeral out of state. He ordered her to return the body for a more thorough autopsy. Esmolol toxicity was established as the cause of death.

If the facts can be proven, the family has the right to recover damages from the doctors, the nurses and the hospital for intentional misrepresentation and for intentional infliction of emotional distress.

COURT OF APPEAL OF FLORIDA
May 7, 2010

Although the necessary facts remain to be proven, the Court of Appeal of Florida ruled the family members are entitled to their day in court even if they cannot prove that a negligently administered medication overdose was what killed their loved one.

The family can allege in court that they suffered emotional harm if the patient's caregivers did conspire to misrepresent the cause of their mother's death and thereby cause a grossly outrageous mishandling of their late mother's remains. **Thomas v. Hospital Board, ___ So.3d __, 2010 WL 1816251 (Fla. App., May 7, 2010).**

Pneumonia: Nurse Practitioner Met Standard Of Care.

The Court of Appeals of North Carolina agreed with the jury's verdict which exonerated a family nurse practitioner from liability for her patient's death.

The Court accepted the testimony of a family nurse practitioner who testified as an expert witness for the defendant family nurse practitioner.

Assessment, Care Appropriate
Patient Died From Other Causes

The patient walked into the clinic with symptoms which had begun three days earlier. He was short of breath and coughing up yellowish phlegm, some of which was blood-tinged. He was not dizzy or nauseous and denied chest pains and heart palpitations.

The nurse practitioner who saw him, whom his widow would later sue, obtained a history of hypertension, diabetes, elevated cholesterol and smoking.

The nurse practitioner's physical exam revealed low blood pressure, elevated heart rate, normal respiratory rate, good skin color, normal mental status and bilateral rhonchi in the lungs.

Her diagnosis was community acquired pneumonia. She gave him a DuoNeb treatment, an albuterol inhaler to take home, IM Rocephin, prescriptions for oral Augmentin and prednisone and a follow-up appointment two days later and sent him to the hospital for a chest x-ray.

Late that same night the wife drove the patient to the E.R. when he started gasping for air. He was dead on arrival.

The autopsy showed few pneumococcus bacteria in the lungs, indicating that the antibiotics had been working, and significant narrowing of the major coronary arteries. Pneumonia was listed as the cause of death, although other medical experts testified in court he died from arrhythmia associated with coronary artery disease.

The jury concluded the clinic nurse practitioner's care was appropriate based on the signs and symptoms she observed. The nurse practitioner had no reason to anticipate he needed to be hospitalized that day for his chronic coronary condition. **Langwell v. Albemarle Family Practice, __ S.E. 2d __, 2010 WL 1754764 (N.C. App., May 4, 2010).**

IV Infiltration: Critical Care Nurse Did Not Meet The Standard Of Care.

The patient was in the critical care unit recovering from coronary bypass surgery. He was under heavy sedation from propofol infusing through an IV in the back of his right hand. He had numerous other IV's infusing at other locations.

Hospital policy required the patient's nurse to check all IV's and document an assessment at least every four hours.

According to the chart, the nurse checked the right-hand IV at 7:00 p.m. when her shift started and again at 4:30 a.m. At 4:30 a.m. significant infiltration of the medication into the surrounding tissues was discovered, which led to complications from tissue damage.

It is below the standard of care not to check an IV every four hours if required by the physician's orders or by hospital policy.

However, it does not follow automatically that having checked the IV would have prevented tissue damage from infiltration.

CALIFORNIA COURT OF APPEAL
May 6, 2010

The California Court of Appeal agreed with the patient's nursing expert. If no IV checks were documented from 7:00 p.m. until 4:30 a.m., then none were done, and if none were done, the nurse's care of her patient fell below the standard of care.

The Court did not accept the implication from documentation of checks of other IV sites or drawing of blood from another port on the right hand for blood glucoses q 2 hours that the propofol was also checked as often as it should have been.

However, the hospital was found not liable because the patient had no proof that if the IV had been checked as required the bad outcome would not have occurred. **Galvez v. Loma Linda Univ. Hosp., 2010 WL 1806296 (Cal. App., May 6, 2010).**

Overdose: Nurse Ignored Patient's Complaints While Refilling Medication Pump.

The jury in the State Court of Bibb County, Georgia awarded $1,278,321 from an agency which provides skilled nursing services to homebound patients to the family of a deceased patient who lapsed into a coma while an agency nurse refilled her medication pump and died twenty-five days later.

The patient was on medication for chronic pain after her back surgeries. A nurse regularly came to the home to re-inject pain medication into the pump.

On the day in question the patient reportedly complained to the nurse about tingling in her fingers as she was re-filling the pump. The nurse continued injecting pain medication into the pump until the patient became unconscious and the nurse had to start CPR and call 911.

The expert testimony at trial faulted the nurse for not recognizing the patient's complaints of tingling in her fingers as a sign of an overdose. The nurse was found negligent for not stopping the refill procedure at that point. **Hall v. I.V. Care of Middle Georgia, 2010 WL 1673350 (State Ct. Bibb Co., Georgia, January 28, 2010).**

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Abuse: Male Nurse's License Revoked For Misconduct With Vulnerable Female Patients.

The nurse got his license in 1978 and worked at the same hospital more than twenty years before his termination.

After an allegation of sexual abuse against the nurse was ruled unfounded the nurse manager nevertheless met with all the male nurses informally to communicate suggestions for male nurses providing intimate care to female patients. The male nurses were advised to have a female "chaperone" present to protect female patients' dignity and to protect male nurses from allegations of misconduct.

The male nurse, however, was later accused of a number of additional violations of nursing standards. This time the facts were verified by five co-workers in the hospital's emergency department.

The allegations centered on his conduct with young, female, intoxicated patients, some in four-point restraints, with whom he was caught alone in the bathroom or in treatment rooms with the curtains drawn or the doors locked or barricaded with equipment or carts.

One of the nine separate incidents went beyond suspicious circumstances. The nurse was caught in the act sexually abusing a patient under his care in a treatment room with a cart placed behind the closed door to hinder entry by other staff.

The Supreme Court of Massachusetts ruled that that incident alone would justify revocation of the nurse's license. **Duggan v. Board of Registration in Nursing, 456 Mass. 666, __ N.E. 2d __, 2010 WL 1797114 (Mass., May 7, 2010).**

A male nurse declining assistance from a female nurse or nurses aide for intimate care of a female patient is considered an "atypical circumstance" which may be viewed as evidence of intent to engage in improprieties or abuse of female patients.

State nursing regulations prohibit mistreatment in the form of improper confinement of patients, require nurses to protect patient dignity, require nurses to promote public confidence in the nursing profession and require nurses to observe appropriate professional boundaries with patients.

This nurse was guilty of a continuing pattern of intentional behavior which amounts to gross misconduct.

SUPREME COURT OF MASSACHUSETTS
May 7, 2010

Sonogram Gel On The Floor: Patient Slipped And Fell.

The patient got up from bed to go to the restroom, slipped, fell to the floor and was injured just after his nurse had finished a bladder scan imaging test, washed her hands and left the room.

He claimed he saw the nurse shaking her hands as she walked from the bedside to his bathroom to wash the sonogram gel from her hands.

The patient sued the hospital for negligence. The hospital countered by insisting the case be dismissed because the patient did not file an expert witness report with the court to support his case.

The issue in this case is not the standard of care for how much or how little lubricating gel a nurse should use when performing a particular sonogram scan.

It is common knowledge and requires no exercise of professional judgment to recognize that a slippery substance on the floor can cause a person to slip and fall and sustain personal injuries.

COURT OF APPEALS OF TEXAS
May 13, 2010

The Court of Appeals of Texas ruled that this is not a professional malpractice case, but a case of ordinary negligence. As such, the patient does not need an expert witness on professional standards of nursing practice.

The patient was *ad lib* to get out of bed on his own and was not relying on his caregivers for competent assistance at the moment he fell. He had the same legal status as a patron of a retail establishment who falls on a substance he was not aware of that the proprietor caused to be present or knew about and failed to remove. **St. David's Healthcare v. Esparza, __ S.W. 3d __, 2010 WL 1930222 (Tex. App., May 13, 2010).**

Dialysis: Motor Vehicle Accident On The Way Home.

The patient was injured in a motor vehicle accident while driving herself home from her dialysis treatment. The investigating police officer determined it was her own inattention that caused her to rear-end another vehicle.

The patient sued the dialysis facility. In her lawsuit she alleged that the nurses negligently gave her the OK to drive herself home without fully assessing her vascular stability, that is, without taking a standing blood pressure after she was done with her dialysis treatment. A standing blood pressure, it was alleged, would have shown she was hypotensive as a result of fluid loss during the treatment.

The patient's nursing expert is prepared to testify that the type of treatment the patient received can increase the patient's chance of blood pressure instability, dizziness and fatigue.

However, there is no solid evidence the patient was hypotensive at the time of the accident or that hypotension caused her inattention to her driving.

UNITED STATES DISTRICT COURT
NEW JERSEY
May 7, 2010

The US District Court for the District of New Jersey dismissed the patient's case.

The patient's nursing expert was only able to say in general terms that dialysis treatment can leave a patient hypotensive and that driving while hypotensive can be hazardous, but she had no basis to testify that this patient was in fact hypotensive when she had her accident.

The patient herself did not complain that she felt dizzy, fatigued or otherwise impaired. The Court did not see any necessity for the nurses to have obtained a standing blood pressure in the absence of such symptoms. **McHugh v. Jackson, 2010 WL 1875578 (D.N.J., May 7, 2010).**

Sexual Harassment: Physician Was Not A Hospital Employee.

The New Jersey Superior Court, Appellate Division, ruled that the hospital could not get around liability in a staff nurse's sexual harassment lawsuit by claiming that the physician/perpetrator was not a hospital employee but instead was only an associate of an independent medical-practice group whose members had staff privileges to practice at the hospital.

The fact the hospital had an anti-harassment policy is no defense.

It was not entirely clear whether the policy applied to non-employees, whether it was communicated to the physician or whether any attempt was made to enforce it with the physician in this particular case.

That is, the hospital's policy was not an effective anti-harassment policy.

NEW JERSEY SUPERIOR COURT
APPELLATE DIVISION
April 28, 2010

An employer has a legal obligation to take affirmative measures to deter sexual harassment before the fact and to stop it once it is reported.

The hospital apparently did not require non-employee physicians practicing at the hospital to participate in sexual harassment training and was at best only equivocal in dealing with it after it occurred.

The Court said that a perpetrator crosses the line from obnoxious behavior which might not be serious enough for a lawsuit to outright harassment when unwanted touching of a sexual nature occurs. **Collelo v. Bayshore Community Health, 2010 WL 1753164 (N.J. App., April 28, 2010).**

Emergency Room: Missed Diagnosis, US Court Finds No Nursing Negligence.

The US District Court for the Middle District of Florida carefully reviewed the nursing and medical care the patient received on the day in question and concluded there was no departure from the standard of care.

History of Lower Back Problems

When the patient arrived at the hospital's emergency department the triage nurse on duty immediately obtained a history from the EMT's who brought her in. The history that the EMT's had obtained from the patient was that she had had chronic back problems for years which were causing her constant pain.

Nonetheless, that morning, although she was in intense pain, she still could move all her extremities and she denied falling, losing consciousness, nausea, vomiting, dizziness, numbness, tingling, recent heavy lifting or recent surgery.

The nurse then began his own assessment, all the while documenting on the hospital's standard form the data he obtained which he would later have in front of him when he had to testify in court.

Nursing Assessment
Patient Not Categorized as Emergent

The patient was not in distress, denied numbness, tingling or weakness, was able to move all her extremities and reported no problems with bowel or bladder incontinence. Her vital signs were basically normal, not consistent with a person in severe distress, although the patient continued to rate her pain as 10/10.

A hospital staff nurse took over responsibility for the patient about two hours later. There was some difficulty obtaining a urine sample, but one was finally obtained. The nurse believed the difficulty was explained by the patient having to urinate into a bedpan while lying flat on her back, an unusual experience for her.

After the physician's exam the staff nurse discharged the patient with instructions to rest, take her medications and to be sure to keep her already-scheduled appointment with her neurologist four days later. **Millard v. US, 2010 WL 1949639 (M.D. Fla., May 14, 2010).**

The patient was misdiagnosed as suffering from a flare-up of chronic lower back pain for which she had been under a physician's care for some time.

In fact, there was an extruded disc in her lower back whose onset probably occurred earlier that morning which was not discovered until a visit to another E.R. two days later.

Cauda equina syndrome resulted from the fact the extruded disc was not caught and operated upon promptly, an outcome the patient's lawsuit alleged was avoidable.

The patient suffered bowel, bladder and sexual dysfunction and sensory and motor nerve damage in both her lower extremities.

However, given the patient's history and presenting signs and symptoms when she arrived in the E.R., the nursing triage assessment, medical exam and nursing care at discharge were all within the standard of care.

The hospital would only be liable to the patient if the patient could prove its employees departed from the applicable standard of care.

UNITED STATES DISTRICT COURT
FLORIDA
May 14, 2010

Emergency Room: Nurses, Doctors Failed To Notice, Remove Field Bandage Applied By EMT's.

The patient arrived at the hospital unconscious with an IV in her right leg just below the knee. The IV was secured in place with a bandage around the leg the EMT's had applied in the patient's home before transporting her.

The patient was treated in the hospital's cardiac catheterization lab and then transferred to intensive care.

Not until 28 hours after she arrived in the emergency room did a nurse in the intensive care unit notice swelling around the bandage holding the IV needle in place below the knee.

The bandage was promptly removed. However, due to necrosis of the skin, muscles and tendons, the leg had to be amputated below the knee. The surgeon who performed the amputation referred in his report to a tourniquet-like effect of the bandage on the leg while more than 10 liters of fluid were infused through the IV.

The only issue is the relatively straightforward standard of care for a nurse or physician with an unconscious or semi-comatose patient with a restrictive bandage on an extremity.

The case has nothing to do with the cardiac catheterization itself.

COURT OF APPEALS OF TEXAS
May 14, 2010

The Court of Appeals of Texas ruled the patient's medical and nursing experts' reports squarely defined the standard of care and made out a case of negligence against her caregivers. **Hayes v. Carroll, __ S.W. 3d __, 2010 WL 1930151 (Tex. App., May 14, 2010).**

Correctional Nursing: No Care Plan For Diabetic Inmate With Foot Ulcer.

The Court of Claims of New York awarded $1,020,916 for nursing and medical malpractice to the estate of a former prison inmate who died after his release from prison from septic shock related to infection of a diabetic ulcer on his right big toe from which he suffered while he was an inmate.

A nurse performed a health screening when he was transferred from one correctional facility to a different facility within the state prison system.

The nurse made note that he was diabetic, walked with a limp and had a sore of some sort on his right foot. She claimed she also reviewed all of the inmate's previous medical records.

The nurse, however, did not physically examine the foot to assess the nature of the lesion or to determine whether it was infected, but she did make a recommendation he be examined by a physician. That exam did not take place until five days later.

In the meantime the nurse released the inmate to work in the kitchen, which required prolonged standing and walking, a decision which was soundly criticized in the family's lawsuit.

The patient eventually came under a physician's care, started taking antibiotics and continued treating after his release.

The nurse first saw him in September, 2005. He was released in August, 2006 and died in June, 2007 from a massive pulmonary embolism related to deep vein thrombosis after multiple debridement surgeries on the toe and foot.

The family's lawsuit, as it pertained to the health-screening nurse, alleged she should have physically examined the patient, should have become aware of the nature of his foot lesion and should have immediately started a nursing care plan to address the specific needs of a diabetic patient with a toe ulcer that was either already infected or had a high potential for infection. **Estate of Pickell v. New York, 2009 WL 6407960 (N.Y.Ct.Cl., November 19, 2009).**

Resident Elopement, Death: Facility Charged With Involuntary Manslaughter.

The Supreme Court of Massachusetts reviewed the unsettling series of events leading up to a nursing home resident's tragic death, only to conclude that under the circumstances the law does not support a prosecution for involuntary manslaughter against the nursing home's parent corporation.

That is, the system in place at the nursing home failed this resident, but the actions of no single employee, although negligent, could be pointed to as grounds for a criminal prosecution.

The Court dismissed the charges that the local prosecutor had filed against the parent corporation.

Resident Known to Wander

The resident was admitted to the facility with medical diagnoses that included organic brain damage and dementia.

Three years later she was found by staff sitting in her wheelchair in the front entrance foyer, the small space between the inner and outer front doors.

She was recognized at once as an elopement risk. The nursing staff obtained an order from her physician for a specific brand of signaling device she was to have on her person at all times. It sounded an alarm and automatically locked the front door any time the resident came into close proximity with the entrance way.

At least twice after she got the device, probably more often, she tried to wheel herself out the front door but was stopped cold. Staff at the facility were fully aware she was an ongoing elopement risk.

Documentation Mix Up
Physician's Orders
Removed From the Chart

The resident's treatment sheet had to be initialed once each day, among other things, to document that she had her WanderGuard on her person and that it was checked to verify it was working properly.

Each month two nurses independently audited the treatment sheets to insure they were being reviewed and checked off each day by the patient's nurse. The patient was consistently using her WanderGuard and the nurses were documenting it.

However, at some point the director of nursing had someone "clean up" the treatment sheets. The person to whom that task was delegated mistakenly thought it meant deleting certain physicians' long-standing orders including those for WanderGuards.

One night a fill-in nurse was working. She had no way of knowing the resident was supposed to have a WanderGuard, did not see it on the treatment sheet and did not verify that the resident was wearing it. An aide left the resident near the front entrance, presumably thinking there was no problem since she had a WanderGuard.

The resident quickly wheeled herself through both front doors, fell down the eight front steps, hit her head and died from her injuries. **Commonwealth v. Life Care Centers, __ N.E. 2d __, 2010 WL 1964627 (Mass., May 19, 2010).**

An avoidable series of failures within the system resulted in this resident, a dementia patient, wheeling herself out the front door, falling down the front steps and being killed.

No single error or omission or the actions of a single nursing home staff member can be singled out to as the reason this happened.

The prosecution wants to aggregate all the separate errors and omissions which occurred into a single indictment of involuntary manslaughter committed by the nursing home's parent corporation, but that is not a valid legal premise.

SUPREME COURT OF MASSACHUSETTS
May 19, 2010

Post-Surgical Care: Nurses Did Not Monitor The Patient.

The fifty-seven year-old patient had had a discectomy and fusion of a herniated lumbar disc.

Right after the procedure he complained to the nurses about pain and numbness in his left foot. The nurse noted the foot was cool but the patient had sensation and could move the foot. The other foot reportedly was warm and had brisk capillary refill. Three hours later the patient was in intense pain. Two hours after that, at the 9:00 p.m. change of nursing shifts, the left foot was cold.

The jury heard conflicting testimony from the nurses and the physician as to whether the nurses notified the physician what was going on with the patient that afternoon and evening.

However, after the 9:00 p.m. nursing shift change there was nothing in the chart about the problem for almost 12 hours.

The next morning the patient's foot was cyanotic and partial a amputation had to be done.

DISTRICT COURT
HIDALGO COUNTY, TEXAS
April 13, 2010

Shortly before 9:00 a.m. the next morning the left foot was cyanotic and the patient was unable to move his toes.

Emergency surgery was successful in saving the leg itself but part of the foot had to be amputated.

The hospital paid $250,000 during pretrial mediation to settle the patient's case that was filed in the District Court, Hidalgo County, Texas. **Salinas v. McAllen Hospitals, 2010 WL 1953614 (Dist. Ct. Hidalgo Co., Texas, April 13, 2010).**

Post-Surgical Care: Patient Has Complications After Bypass.

The fifty-eight year-old patient had coronary artery bypass surgery which involved harvesting a portion of the saphenous vein from his left thigh.

The wound on his left thigh was wrapped with an elastic bandage on the leg from foot to thigh, the rationale being to prevent swelling.

Orders from the physician called for the elastic bandage to be removed 24 hours after it was applied.

The patient's nurses did not remove the elastic bandage for 30 hours. By that time a pressure wound had developed just above the knee. The patient later developed a chronic pain condition in the foot.

The patient's nursing expert testified that physician's orders to remove the elastic wrap at 24 hours should have been followed exactly as written.

SUPERIOR COURT
LOS ANGELES COUNTY, CALIFORNIA
March 12, 2010

The jury in the Superior Court, Los Angeles County, California awarded $787,503 to the patient, 40% percent from the physician's assistant because he applied the elastic wrap too tightly in the first place and 60% from the hospital because the nurses did not properly assess it and promptly remove it at 24 hours.

The jury heard testimony that the nurses should have realized from their own assessments that the bandage was too tight and should have taken action, even though it was not their fault it was applied to tightly by the physician's assistant.

The patient's nursing expert also stated that the nurses had no discretion in interpreting the physician's orders. The orders did not give them the option to remove the wrap at 24 hours; they were compelled to do so at that time. **Hale v. Yokoyama, 2010 WL 1953571 (Sup. Ct. Los Angeles Co., California, March 12, 2010).**

Bed Rails: Nursing Home Patient Dies From Asphyxiation.

The eighty-three year-old patient was suffering from what was described as end-stage dementia.

While sleeping in her bed in a hospital's skilled nursing facility her head became trapped between the bed and the bed rails with her face down against the mattress.

The patient was found dead from asphyxiation.

The family's lawsuit filed in the Supreme Court, Clinton County, New York alleged that it is below the standard of care for an elderly dementia patient who does not need bedrails for his or her own safety to have bedrails on the bed, given the potential danger of entrapment of the head and resulting asphyxiation. The facility had actually already begun removing the bedrails from some of the other beds.

The lawsuit also claimed there should have been a monitor installed, although the nursing home's experts were prepared to argue that would not have made a difference because the nurses routinely get lots of false alarms from bed monitors that do not signal anything wrong with the patient.

The facility agreed to a $190,000 settlement after the jury had deliberated three days without reaching a verdict one way or the other. **D'Aust v. Champlain Valley Physicians Hosp., 2010 WL 1747533 (Sup. Ct. Clinton Co., New York, March 17, 2010).**

Fall: Jury Awards Damages.

The elderly patient fell from his hospital bed twice between 7:30 p.m. and 2:00 a.m. His lawsuit in the Circuit Court, Broward County, Florida alleged his fall risk should have been assessed on the Morse Fall Assessment Scale and that a sitter should have been provided.

The jury awarded $1,364,582 but ruled at the same time that the patient himself was 65% at fault. **Indeck v. Healthsouth, 2010 WL 1953548 (Cir. Ct. Broward Co., Florida, April 9, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

OSHA: Occupational Exposure To Infection, Healthcare Workers.

The US Occupational Safety and Health Administration (OSHA) recently published an announcement in the US Federal Register (May 6, 2010) containing a comprehensive statement of its current recommendations and regulatory guidelines related to occupational exposure of healthcare workers to infectious agents.

OSHA is asking for public comments to be submitted by August 4, 2010 as to regulatory changes the public might want to suggest.

We have placed the document on our website at www.nursinglaw.com/OSHA050610.pdf.

In a separate announcement (May 14, 2010) OSHA published a thumbnail sketch of the agency's current recommendations and guidelines specifically for bloodborne pathogen exposure, again asking for public comments as to changes that might be called for.

This document is on our website at www.nursinglaw.com/OSHA051410.pdf.

FEDERAL REGISTER May 6, 2010
Pages 24835 - 24844
FEDERAL REGISTER May 14, 2010
Pages 27237 - 27239

Discrimination: Haitian Man Fired, Cell Phone Use On The Job.

A family member complained to management because three nursing home employees were using her mother's room as a place to "hang out" and talk on the cell phone.

The three, two white or Hispanic females and a black man from Haiti, were working together that day. When the daughter walked in on them they were waiting around while one of the females finished a personal cell phone call.

The director of nursing, a white female, decided to fire the black Haitian man over the incident. He filed a discrimination complaint against the nursing home.

The US District Court for the District of New Jersey acknowledged that all three of the employees were at fault for "hanging out" in a resident's room and the one female was at fault for making a personal cell phone call on the job.

That being said, it was discriminatory for the black man from Haiti to be singled out for a harsher punishment. His race, nationality and gender were the only factors that explained why he was treated differently. **Angrand v. Paragon Village, 2010 WL 1644132 (D.N.J., April 22, 2010).**

Religious Discrimination: Court Defines The Limits Of Exemption For Religious Institutions.

A geriatric nursing assistant who worked in a nursing home associated with the Catholic faith was a member of a religious group known as the Church of the Brethren.

As a member of that faith she wore long skirts and a head covering at all times, including on the job. Her manner of dress did not interfere with performance of patient care tasks.

The facility's director of nursing reportedly told her that her clothing was not appropriate in a Catholic institution and made residents and their families feel uncomfortable. She insisted that the nursing assistant dress in a more conventional style.

The director of nursing eventually terminated the nursing assistant, who filed a lawsuit alleging discrimination in violation of the US Civil Rights Act.

A healthcare employer associated with a particular religious denomination is permitted to discriminate in favor of persons within the same faith, as far as hiring decisions are concerned.

This narrow exemption for such institutions from the general rule of non-discrimination does not give carte blanche to other forms of discrimination based on religion.

UNITED STATES DISTRICT COURT
MARYLAND
April 30, 2010

The US District Court for the District of Maryland pointed out that religious institutions were originally exempted from the US Civil Rights Act, but then an amendment was passed subjecting them to the Act in all respects except that hiring decisions may still be made preferentially on the basis of membership in the same faith.

However, according to the Court, the Act does not allow an employer associated with a particular religious denomination to subject an employee of another faith to on-the-job harassment based on the employee's own different religious beliefs or practices.

The nursing assistant's case can go forward inasmuch as she is alleging religious harassment in violation of Federal law. **Kennedy v. Villa St. Catherine's, __ F. Sup. 2d __, 2010 WL 1741125 (D. Md., April 30, 2010).**