LEGAL EAGLE EYE NEWSLETTER

March 2009 For the Nursing Profession Volume 17 Number 3

Substandard Nursing Practice: Employment Termination, License Probation Upheld.

The Court of Appeals of Michigan ruled the LPN's employer had the right to terminate him and the state bureau of health professions had grounds to suspend his license for two years for substandard nursing practice.

If Care Is Not Documented Care Is Presumed Not Given

An emergency department patient in the midst of a sickle-cell crisis had various measures ordered for her by the emergency department physician, including an EKG, chest x-ray, lab work and medications.

The chart, however, contained no documentation by the nurse of any follow-up on the physician's orders.

Failure to document patient care is substandard nursing practice, the court pointed out. Going further, failure to document leads to a legal presumption of a more serious departure from professional standards, that is, that the care in question was not given at all.

The nurse testified he actually did comply with the orders, in part, by sending the patient off to the x-ray department ten minutes before the end of his shift.

Even if that could be accepted as true the nurse was still at fault for failing to report about the patient to the next nurse coming on duty.

Failure to document patient care in the chart is a violation of nursing standards of care, even if no actual harm comes to the patient.

When care is not documented in the chart there is a legal presumption of an even more serious departure from professional standards, that is, that the care in question was not given at all.

COURT OF APPEALS OF MICHIGAN
February 12, 2009

Being busy with other patients is a poor excuse for failing to attend to a patient. Raising that as an excuse is pure speculation when the nurse cannot specifically remember the events in question.

A healthcare employer has the right to insist upon a skills reassessment after probable cause is found that a nurse has been derelict in patient care.

Failure to cooperate with correction and to show improvement can be grounds for termination, the court pointed out.

Faulty Patient Assessment

Another patient, a hypertensive diabetic, came to the emergency department with complaints of heartburn for more than a week. Without even taking vital signs the nurse decided it was just heartburn, the patient was not really ill and no further diagnostic work-up was appropriate because tests cost money. The nurse did not have the patient seen by the physician.

Another nurse took over the patient's care and immediately took vital signs, put the patient on a cardiac monitor and reported to the physician that they could have a cardiac patient on their hands.

The patient was not harmed. However, actual harm versus the potential for harm is an irrelevant issue when a nurse's basic assessment skills are being questioned. **Dept. of Health v. Rahe, 2009 WL 348822 (Mich. App., February 12, 2009).**

Inside this month's issue ...

Substandard Nursing Practice - Neonatal Intensive Care
E.R./Cardiac Patient - Medication Error - Brain Injury/Choke/Death
Home Health - Fall/Incident Report - Bladder Program
Babies Switched In Nursery - Nurse Refused To Alter Chart
Epidural/High Spinal Block - E.R./Spinal Trauma - HIPAA
ICU/Alarms Not Heard - Hearing-Impaired Nurse/Discrimination
Arbitration - E.R./Stroke/Nursing Assessment/Nursing Expert
Nurse/Patient Advocate - Post-Op/Restraints - Call Light

March 2009

New Subscriptions See Page 3

Neonatal Intensive Care: Nurses Delayed Reporting To Physician.

The baby was born at twenty-seven weeks and died twenty hours later in the neonatal intensive care unit.

The nurses reportedly observed and charted that the baby was breathing rapidly and showed other signs of respiratory distress including subcostal retractions, color changes and gasping. The capillary blood gases also had come back abnormal.

When the neonatologist phoned in for a report he was reportedly told the vital signs and other assessment data were fine.

It was not until four and one-half hours after signs of respiratory distress appeared, when the O_2 sat dropped into the 60's, that the neonatologist was contacted and told something was seriously wrong.

The parents' lawsuit in the District Court, Webb County, Texas settled for $250,000, 60% from the hospital and 40% from the physician. **Elizarde v. Laredo Reg. Med. Ctr., 2009 WL 294506 (Dist. Ct. Webb Co., Texas, January 26, 2009).**

Choking: Brain Injury Patient Served Burrito.

A forty-seven year-old brain injury patient had a history of choking and was diagnosed with dysphagia. His care plan called for full assistance when eating.

A burrito was served to him which he grabbed impulsively and stuffed into his mouth. The Heimlich maneuver was reportedly delayed while his code status was clarified by means of a phone call to the family. The family settled their wrongful-death lawsuit filed in the Superior Court, Orange County, California, for $1,000,000. **"John Doe" v. Unnamed Nursing Home, 2009 WL 294474 (Sup. Ct. Orange Co., California, January 15, 2009).**

Emergency Room: Cardiac Patient's Care Delayed.

The patient came to the emergency room complaining of chest pain, shortness of breath and abdominal pain. He stated he had recently vomited.

He was reportedly kept waiting almost two hours without a physician seeing him or a nurse monitoring his vital signs.

When he finally got a triage assessment his BP and O_2 sat were low. Instead of being seen by a physician he was taken to the hospital business office to sign paperwork. Then he was returned to the waiting room for another half-hour wait.

A physician finally did see him, drew blood for cardiac enzymes, called the cardiologist and sent him to the catheterization lab, where he went into full cardiac arrest and died during a coronary angiogram.

The widow agreed to settle the case, filed in the District Court, Harris County, Texas, for $30,000. **Gillie v. Memorial Hermann Hosp., 2008 WL 5582213 (Dist. Ct. Harris Co., Texas, October 16, 2008).**

Medication Error: Jury Awards Damages.

The nursing staff gave medications to the ninety year-old resident's daughter for the next day's home visit. The a.m. medication was an oral diabetes medication actually belonging to another resident.

A facility staffer called to alert the daughter the next morning. It was too late. The resident had already taken the wrong medication and had lapsed into a coma.

The jury in the Circuit Court, Dane County, Wisconsin, awarded damages for the deceased's medical and funeral expenses. The jury ruled the daughter herself 22% at fault. **Kinney v. Harmony Living Centers, 2008 WL 5605696 (Cir. Ct. Dane Co., Wisconsin, June 6, 2008).**

Fall: Nurses Neglected To Catheterize The Patient.

The elderly resident fell in her room approximately one month after she was admitted to long term care.

The resident had a bladder-retention problem and was on a program for regular urinary catheterization by the nursing staff. One evening the nurses did not perform the procedure. The resident had the urge to urinate and had to get up by herself. While trying to ambulate to the restroom her bladder voided spontaneously. She slipped and fell in the puddle of her own urine.

She fell again about a week later. At that point a CT scan revealed a spinal compression fracture from one of the falls.

The New York Supreme Court, Appellate Division, ruled the resident had grounds to sue for common-law malpractice and for violation of the state's nursing home residents' bill of rights statute. **Kash v. Jewish Home, __ N.Y.S.2d __, 2009 WL 323306 (N.Y. App., February 11, 2009).**

Home Health: MS Patient's Care Plan Not Adequate.

A fifty-one year-old home health client had been disabled by MS and confined to a wheelchair since age twenty-one.

She developed pressure sores, with MRSA involvement, apparently because she stayed in her chair all day and her care plan did not call for her home health worker to get her out of her chair on a regular basis to assess skin integrity.

Her lawsuit, filed in the Superior Court, King County, Washington, settled for $600,000. **Leonard v. City of Seattle & Millennia Healthcare, Inc., 2008 WL 5573244 (Sup. Ct. King Co., Washington, October 28, 2008).**

Single Person Transfer: Fall, Death, Sizeable Verdict For The Family.

The ninety year-old nursing home resident was dropped and struck her head on the floor during a single-person transfer from her wheelchair to her bed.

She was taken to the hospital for stitches and an x-ray. The nursing home refused to take her back, reportedly because of her now-diminished mental status. She was sent back to the hospital.

At the hospital a diagnostic scan revealed intracranial bleeding. The patient died in the hospital the next day from head trauma from the fall.

The nursing home's lawyers reportedly based their defense strategy on drawing attention to her pre-existing medical problems, including a urinary tract infection, osteoporosis, hip fracture, stroke, seizure disorder and dysphagia with a PEG tube. The jury in the Probate Court, Bexar County Texas, awarded her two sons $1,146,000. **Penalver v. Living Centers of Texas, 2009 WL 294505 (Prob. Ct. Bexar Co., Texas, January 22, 2009).**

LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

ISSN 1085-4924

© 2009 Legal Eagle Eye Newsletter

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

Published monthly, twelve times per year.
Mailed First Class Mail at Seattle, WA.

E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
PO Box 4592
Seattle, WA 98194–0592
Phone (206) 440-5860
Fax (206) 440-5862
kensnyder@nursinglaw.com
www.nursinglaw.com

Fall: No Nursing Negligence, Lawsuit Dismissed.

There is no evidence the patient's nurses were negligent in any respect.

Further, there is no evidence this episode, even if it can be categorized as a fall, caused or contributed to the patient's death. She was transferred back to the hospital seven weeks later and died of heart failure.

The family's lawsuit merely alleges that facility personnel negligently dropped the patient in a transfer, then tried to cover up the incident, and the alleged cover-up caused the son grave concern over the quality of care being given to his mother.

A professional malpractice case has to be supported by evidence that the patient was injured by an error or omission which fell below the prevailing professional standard of care.

COURT OF APPEALS OF TENNESSEE
January 30, 2009

The Court of Appeals of Tennessee affirmed the local court's decision to dismiss the lawsuit the family had filed against the rehab facility, finding no nursing negligence.

The lawsuit alleged the deceased was "dropped and fell violently and painfully to the floor." The adult son was prepared to testify his mother had told him that two nurses came into the room and tried to lift her to the commode, but all three fell at once and his mother hit the floor. Afterward the facility denied any knowledge of the incident whatsoever.

The son's testimony was overruled as hearsay.

The only creditable evidence, according to the court, was the sworn affidavit of the patient's nurse taken *verbatim* from the incident report she wrote up on the evening in question:

"On the evening of June 5, 2005, I was in Room 2229 with the patient, Betty Stratton. My purpose in being in the room was to assist her to a bedside commode. We were waiting for a second assistant to come help us when the patient slid off her bed into my arms. She did not strike the floor and I slowly lowered her to the floor. She was actually sitting on my feet when assistance came to the room and we lifted her onto the bedside commode. Mrs. Stratton did not fall to the floor. There was no visible injury as a result of her sliding off the bed into my arms." **Luter v. Vanderbilt Stallworth Rehab Hosp., 2009 WL 230231 (Tenn. App., January 30, 2009).**

Clip and mail this form. Or if you prefer order online at www.nursinglaw.com

Print $155/year _____ Online $95/year _____ Phone 1-877-985-0977

Check enclosed _____ Bill me _____ Credit card _____ Fax (206) 440-5862

Visa/MC/AmEx/Disc No. ______________________________

Signature ______________________ Expiration Date __________

Name ______________________________
Organization ______________________________
Address ______________________________
City/State/Zip ______________________________
Email (If you want Online Edition*) ______________________

***Print subscribers also entitled to Online Edition at no extra charge.**

Mail to: Legal Eagle Eye PO Box 4592 Seattle WA 98194-0592

Babies Switched In Nursery: Court Allows One Of The Mothers To Sue For Damages.

Each of the two mothers has filed suit because one of them was allowed to nurse the other's baby, due to a mix-up committed by the neonatal nursing staff.

COURT OF APPEALS OF TENNESSEE
January 27, 2009

One of the mothers was given an infant to nurse and nursed her for a time until she realized she did not look like her own baby. The mother checked the ID bracelet on the baby's ankle, realized it was not her own baby and jumped right up out of bed, injuring her sutured incision.

The neonatal nursing staff admitted there was a mistake. They went to the bassinet with her last name and found the ID bracelet on the infant inside had the other mother's last name. They put her name on a new ID bracelet for the baby and tried to assure her that the mix-up had been solved.

She was still understandably quite concerned. DNA testing was ordered on hers and this baby's blood samples to establish that she had the right infant.

The same infant was sent home with her when she was discharged. Her anxiousness continued for ten days until the DNA results came back and proved she now really had the right baby.

The Court of Appeals of Tennessee ruled this mother did have the right to sue for her own mental anguish and emotional distress, from the time she discovered the mix-up until the DNA results came back.

It did not matter that her attorney was the one who finally sent her to a psychiatrist, basically so there would be expert testimony as to her anxiety reaction to prove damages in her lawsuit. **Filson v. Seton Corp., 2009 WL 196048 (Tenn. App., January 27, 2009).**

One of the mothers was resting comfortably in her hospital room when she was informed that her infant had been taken from the nursery and given to another new mother to nurse.

As a precaution, the other mother's breast milk was suctioned from the baby's stomach, along with glucose water that had earlier been given to the infant, pending blood tests on the other mother to rule out any infection that could be passed by her breast milk. The tests proved negative.

The Court of Appeals of Tennessee ruled the infant suffered no harm by being nursed by another person and having her stomach contents removed. There was no medical battery committed because the procedure was done pursuant to a physician's order and fell within the general consent to treatment papers the parents had signed on the infant's behalf. **Hobbs v. Seton Corp., 2009 WL 196040 (Tenn. App., January 27, 2009).**

Epidural: High-Spinal Block During Catheter Replacement.

The patient's epidural catheter was being replaced for post-op pain management. She arrested for at least ten minutes before cardiac and respiratory function could be restored with epinephrine.

In the ensuing arbitration the patient's attorneys argued successfully that she should have been taken back to the O.R. for the procedure, since high-spinal block is a recognized risk and the resources to detect and counteract it promptly are more readily available in the O.R. than on a hospital med/surg floor.

The arbitrator awarded $2,060,569. **Skaggs v. Kaiser Foundation, 2008 WL 5638300 (Med. Mal. Arbitration, Contra Costa Co., California, December 12, 2008).**

Wrongful Termination: Nurse Refused To Alter Chart, Has Grounds For A Lawsuit.

The nurse called the attending physician for permission to give more of a prn anxiety medication early, believing the psychiatric patient was having anxiety and showing extrapyramidal signs (EPS).

The physician told her to give Haldol, which would only tend to increase EPS if that was what was happening. She did give the Haldol and the EPS seemed to increase, so she got another nurse to call and advocate again for the anti-anxiety med. The physician ordered Cogentin. Another physician came in and ordered Benadryl and that finally calmed the patient down.

Two days later the nurse manager and the director of behavioral health ordered the nurse to remove her progress note, rewrite portions they had bracketed for emphasis as not to point fault at the attending physician and insert the new progress note in the chart. She refused and was fired.

Removing or altering progress notes in a patient's chart after the fact is conduct for which a nurse's license can be taken.

A nurse cannot be disciplined or terminated for refusing to do something which is illegal and which could result in loss of the nurse's license.

MISSOURI COURT OF APPEALS
February 13, 2008

The Missouri Court of Appeals ruled the nurse had grounds to sue for damages for wrongful termination. **Hughes v. Freeman Health System, __ S.W. 3d __, 2009 WL 351095 (Mo. App., February 13, 2009).**

ICU: Alarms Sound, Nurse Does Not Respond, Hypoxic Brain Injury Results.

The twenty-two year-old patient underwent a complex procedure at a major teaching facility to resect his brain and skull, then was transferred to the ICU at another hospital. He had been badly traumatized falling from a moving vehicle.

After several weeks he became somewhat responsive but was still on a ventilator with both hands and arms in restraints.

Family Was Told to Leave the Room
Nurse Was in Another Room
With Another Patient

The tragic series of events on the night in question began when the family was asked to leave the room at the change of nursing shifts but were not allowed back in right away when a new nurse came on.

The nurse assigned to the patient was also assigned to another patient in a nearby room. A problem with the other patient's IV line reportedly developed and kept the nurse in that room for a considerable period of time.

No One Heard Or Responded to Alarms
Until It Was Too Late

Meanwhile, the airway of the patient who was alone in his ICU room became obstructed. An alarm sounded as his O_2 saturation dropped. Then he went into bradycardia and eventually asystole which sounded still more alarm tones.

When his situation was finally noticed a code was called and he was resuscitated. However, significant permanent hypoxic brain damage resulted from delay. The patient, starting to respond before, has been completely comatose since.

The lawsuit filed in the Superior Court, Los Angeles County, California settled before trial for $4,750,000. **Confidential v. Confidential, 2009 WL 199777 (Sup. Ct. Los Angeles Co., California, January 5, 2009).**

Hearing-Impaired Nurse: Court Discusses Disability Discrimination Issues.

When an employer becomes aware that an employee has a disability the employer must open lines of communication to see what the employee might need as reasonable accommodation.

The employee has the obligation to communicate the specific accommodations the employee believes he or she needs.

Never requested, and thus non-issues in this case are a stethoscope for use with a hearing aid and an electronic reader board for loudspeaker announcements.

Telephone amplifiers, a TTY telephone and sign language interpretation at in-services functions are different; the nurse requested them and their reasonableness was never fully considered by the employer.

After a patient-safety incident a healthcare employer can require a skills reassessment and a medical fitness for duty examination, even if it goes to the issue of the employee's disability.

In this case the employee herself failed to follow through and was terminated.

UNITED STATES DISTRICT COURT
GEORGIA
February 3, 2009

The US District Court for the Middle District of Georgia put to rest some of the allegations raised in a hearing-impaired nurse's disability discrimination case against her former employer, while allowing other allegations to remain alive for further elaboration of the evidence.

She has profound bilateral hearing loss from Meniere's Disease. Hearing over background noise is very difficult if not impossible. She cannot use a regular telephone or stethoscope, hear overhead announcements or hear monitor alarms.

Patient Safety Incident
Hearing Ability Questioned

A patient-safety incident occurred three and one-half years into her otherwise satisfactory employment as a staff nurse. She could not be contacted by a monitor tech in a patient emergency. She did not carry a portable phone as the other nurses did, not being able to use one, and the tech did not have access to equipment to send a message to the pager she carried as an alternative to a portable phone.

The nurse fortunately just happened to go and check on the patient anyway before harm could occur.

Although she was officially ruled not at fault in the incident she was ordered into a mandatory skills reassessment, which revealed that her basic nursing skills were completely adequate. However, she was also told to report for an audiologist's evaluation for which she failed to report and was suspended and then terminated.

In disability discrimination law it depends on the circumstances of every case whether accommodation requested by the employee is a reasonable accommodation required by law, or, on the other hand, an undue hardship beyond the employer's responsibility. The court must still look at the issue of an amplified phone, TTY and sign language interpreters at in-service meetings. **Wright v. Hosp. Authority of Houston Co., 2009 WL 274148 (M.D. Ga., February 3, 2009).**

E.R.: Pediatric Patient Now Paralyzed Due To Nurse's Negligence.

The whole family was injured in an automobile collision with a drunk driver.

The injuries to the six year-old boy are the issue in a ruling recently handed down by the Supreme Court of Arkansas.

At the scene the child had visible facial lacerations and also seemed to have a fractured wrist. Although he was moving all his extremities he was placed on a spine board with a cervical collar as a precaution by emergency response personnel for transport to the emergency room at the nearest community hospital.

At the hospital he complained to the nurse of abdominal pain and pain in his arms and legs.

The emergency department physician, without examining him, ordered a CT scan of his head, neck, abdomen and pelvis. Afterward it took almost four hours for a physician to look at the CT scan, and when it was read it was incorrectly read as showing no evidence of injury.

After the CT was misread, and before the patient was seen by a physician, the nurse removed the boy's cervical collar, grabbed his arm and started pulling to get him to stand up.

SUPREME COURT OF ARKANSAS
February 12, 2009

The child suffered catastrophic spinal-cord injuries for which the parents were ruled eligible to sue the state's liability insurance pool for compensation in addition to suing the hospital and physician for negligence. **Archer v. Sisters of Mercy Health System, __ S.W. 3d __, 2009 WL 348291 (Ark., February 12, 2009).**

HIPAA: Spouse Has Authority To Obtain Medical Records After Death, Court Says.

The US Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides strong legal protection for the confidentiality of patients' medical records.

The Court of Appeals of Georgia has ruled, however, that a healthcare facility cannot use the Act as a shield to prevent the widow of a deceased nursing home resident from obtaining copies of all the treatment records.

The court framed the issue candidly. It was no secret that the widow, who was represented by an attorney, wanted the records for the express purpose of assessing whether or not to sue the facility for negligence and, if so, for use as evidence against the facility in court.

The surviving spouse has legal authority to file a lawsuit over the circumstances that wrongfully caused the deceased spouse's death.

That brings the widow within the definition of persons authorized to act on the patient's behalf as that phrase is used in the HIPAA.

COURT OF APPEALS OF GEORGIA
February 17, 2009

Another major exception to the general rule of non-disclosure is when the party seeking a patient's medical records has a court order directing the healthcare facility to hand over the records. **Alvista Healthcare Center v. Miller, __ S.E. 2d __, 2009 WL 368383 (Ga. App., February 17, 2009).**

Arbitration: Patient Did Not Sign, Spouse Had No Authority, Case Will Go To Jury.

The deceased resident's widow sued the nursing home where he died, alleging negligence, malpractice and fraud.

The nursing home's first line of defense, before responding to the allegations, has been to insist the case should be decided by an arbitrator, not by a jury. The Supreme Court of Mississippi has ruled there was no valid agreement to arbitrate. The case, therefore, will go before a jury.

Spouse Had No Authority To Sign An Arbitration Agreement

As much as the law favors arbitration of civil disputes, arbitration is fundamentally appropriate only when both sides have agreed to arbitration.

In the context of an individual being admitted for treatment in a healthcare facility such as a nursing home, the arbitration agreement in the admissions papers usually must be signed by the patient. The patient must be fully informed and the signature must be completely voluntary.

A spouse, as a general rule, does not have legal authority to consent to arbitration for the other spouse. Exceptions exist when the patient is now incompetent and the spouse happens to have been named in the patient's durable power of attorney or is the court-appointed legal guardian.

A financial responsibility agreement was signed by the spouse in this case, but, according to the court, that conferred no authority upon her to agree on behalf of the patient to give up his right to sue in civil court.

If an illiterate patient signs with an "X" there must be documentation that the agreement was explained, that the patient agreed and that the mark was intended as a legal signature. **Trinity Mission v. Lawrence, __ So. 2d __, 2009 WL 331629 (Miss., February 12, 2009).**

Transfer Delayed: Nurses Should Have Notified The Physician.

The forty-nine year-old patient collapsed suddenly at home and was taken to the emergency room at a local community hospital.

At the community hospital he was promptly seen by a neurologist and a CT scan was obtained. The CT revealed he had a ruptured aneurysm of the middle cerebral artery.

The neurologist determined that his condition mandated transfer to an urban tertiary care facility. The neurologist's plan to transfer him was based on a core assumption that the patient could and would be sent immediately.

However, the emergency room nursing staff was informed by the tertiary care facility that a bed was not presently available. Four hours went by before the patient was sent.

At the tertiary care facility a repeat CT scan showed the ruptured aneurysm had continued bleeding into the brain, leading to brainstem herniation, brain death and, finally, withdrawal of life support.

Nurses Should Have Reported Delay in Transfer

The widow's lawsuit filed in the Supreme Court, Nassau County, New York, resulted in a settlement of $450,000 during jury deliberations, reportedly right after the jury foreperson asked the judge for a read-back of the transcript of the nurses' trial testimony to clarify the facts.

The widow's lawyers' closing argument to the jury was that the nurses should have realized that immediate transfer was necessary and that the neurologist's order was based on the assumption that transfer could and would happen immediately. As soon as the nurses found out otherwise they had a responsibility then and there to report back. **Bell v. Burstein, 2008 WL 5575011 (Sup. Ct. Nassau Co., New York, November 7, 2008).**

Emergency Room: Court Faults Nurse's Assessment, Relies On Nursing Expert.

It is not a fatal flaw to the patient's lawsuit that his nursing expert has never worked as an emergency room triage nurse.

The basic issue in the lawsuit is nursing standards for assessing patients.

The patient's nursing expert has years of ongoing practical experience in hands-on patient assessment and triage, supervision of other nurses and teaching of nursing students.

She has worked as an office nurse in a family practice setting and as a labor and delivery nurse in a hospital, contexts where fundamental assessment skills are a must.

By law, the expert's report that must be filed along with the initial legal papers in a malpractice lawsuit must come from an expert who is competent to testify.

At a minimum, to be competent to testify, the expert must be licensed and have experience in the area of practice germane to the lawsuit or an academic background teaching in that area.

The patient's nursing expert is competent to testify.

COURT OF APPEALS OF GEORGIA
January 26, 2009

The sixty-one year-old patient's wife brought him to the E.R. because he felt dizzy and had started vomiting.

The triage nurse saw him right away and listened to his health complaints.

An hour later the patient's wife insisted the nurse check him again. He now had what he described as a "twitch" in his chest and his right arm had gone numb.

The nurse reportedly did not have the patient seen by a physician for another three hours.

When he was seen by the physician it was clear the patient had had a massive stroke. He now has significant impairment of the whole right side of his body.

The patient's lawsuit pointed the finger of fault squarely at the emergency room nurse for failing to recognize signs and symptoms of a stroke and for failing to categorize the patient as extremely urgent and to advocate for him on that basis.

Nurse Can Testify As An Expert On Nursing Standard of Care

An affidavit outlining the professional opinion of a registered nurse was filed in support of the patient's lawsuit, and challenged by the hospital's attorneys as insufficient for a malpractice lawsuit.

Assuming the nurse's education, background and professional experience can be substantiated, the Court of Appeals of Georgia ruled there is no reason *per se* to disqualify a nurse as an expert on nursing standards of care.

In making its ruling the Georgia court was compelled to look at the language of Georgia's statute which, like similar statutes in many other states, explicitly states the baseline qualifications that any expert witness in malpractice litigation must have, whether a doctor, nurse or other professional. The nurse's *curriculum vitae* that was attached to her affidavit showed she met or exceeded the state's standards, the court said. **Houston v. Phoebe Putney Mem. Hosp., __ S.E. 2d __, 2009 WL 161738 (Ga. App., January 26, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Nurse As Patient's Advocate: Nurses' Inaction Had No Effect On Outcome, Court Says.

The Court of Appeals of Michigan dismissed the patient's lawsuit. The lawsuit alleged that the hospital's nurses failed to report his condition to the attending physician and failed to advocate for changes in his treatment plan.

The court pointed out there was no proof offered on the patient's behalf that, in fact, the attending physician would have taken a different course if the nurses had advocated for it.

The only relevant evidence was the testimony of the physician who took over as attending ten days later. He said there was nothing the nurses could have pointed out that the earlier attending physician did not already know at the time and no reason at the time for the physician to have changed the plan of care. **Martin v. Ledingham, __ N.W. 2d __, 2009 WL 196178 (Mich. App., January 27, 2009).**

Post-Op Care: Neurosurgery Patient Had Eluded Restraints, Yet No Sitter Was Ordered.

The thirty-three year-old patient was admitted to a rehab facility following removal of a brain tumor at a nearby teaching hospital.

In rehab she fell out of bed twice and fell once from her wheelchair, each time after working herself free from restraining straps.

One-on-one supervision was reportedly allowed by the facility's policies in some cases. The deceased patient's family's expert witnesses were prepared to testify this was a situation clearly calling for such close supervision.

The patient died following unsuccessful surgery to correct an cranial hematoma from head trauma from the last fall. The family's lawsuit filed in the Superior Court, Essex County, New Jersey settled before trial for $850,000. **Kimble v Kessler Inst., 2008 WL 5574834 (Sup. Ct. Essex Co., New Jersey, December 15, 2008).**

Call Light Not Answered, Patient Falls, Dies: Nursing Facility Found Liable To Patient's Family.

The eighty-seven year-old patient was placed in the facility for recovery from spinal surgery.

The family had researched the issues carefully while trying to find a suitable placement. A representative of this facility and a hospital discharge planner both assured them this facility had exceptional call-light response times, usually within two to three minutes.

The patient, already set for discharge later that day, called for help to the restroom. No one responded. She could not wait so she got up on her own. She fell and twisted her ankle.

X-rays were taken which staff interpreted as negative. The patient was discharged as planned. Two days later her physician found two fractures on the x-rays and scheduled surgery.

Two- to three-minute call-light response times were among the promises made in the brochure given to the family by the nursing facility's admissions counselor.

In fact, the facility had been cited numerous times by the state department of public health for negligent fall-prevention practices and for delayed call-light responses leading to injury accidents.

DISTRICT COURT, LARIMER COUNTY
COLORADO
September 15, 2008

The patient never recovered from the surgery.

The family's lawsuit alleged negligence for failing to respond to her call light promptly.

The lawsuit went on to allege violation of the state's consumer protection act and breach of contract based on alleged misrepresentations made before admission as to the high quality of care.

The jury in the District Court, Larimer County, Colorado awarded the family $375,000. The verdict was reduced to $300,000 because of Colorado's cap on non-economic damages and then further reduced to $225,000 based on contributory negligence by the patient herself. **Wolfe v. Canyon Sudar Partners, 2008 WL 5568178 (Dist. Ct. Larimer Co., Colorado, September 15, 2008).**