LEGAL EAGLE EYE NEWSLETTER

March 2011 *For the Nursing Profession* Volume 19 Number 3

EMTALA: E.R. Staff Did Not Follow Hospital's Screening Process, Lawsuit Goes Forward.

A young woman in labor left the emergency department at the hospital and went to another hospital after it appeared to her that the emergency department staff were unwilling to treat her.

At the second hospital, after a considerable wait in the emergency department, she gave birth to a stillborn child.

The US District Court for the District of Nevada saw grounds for a lawsuit for violation of the patient's rights under the US Emergency Medical Treatment and Active Labor Act (EMTALA).

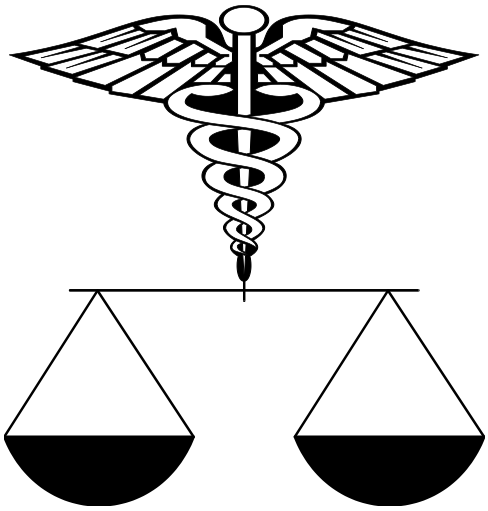
Full Admission Paperwork Required Before Being Seen

The E.R. front desk at the first hospital apparently told the patient she had to complete all of her admitting paperwork before she could be seen by anyone, even the triage nurse.

That went contrary to the hospital's standard Quick Patient Identification process and it gave this patient the subjective impression that the hospital was not willing to treat her.

Hospital's Standard Procedure Quick Patient Identification Process

The hospital's standard procedure was for the emergency room front desk to notify the triage nurse immediately of any new patient arriving in the emergency department.



A medical screening examination is adequate for purposes of the EMTALA if it is the same as the care that is routinely offered to other patients presenting with the same or similar symptoms.

If a particular patient's case is handled differently than other patients' cases are handled and the patient suffers, the patient can sue.

UNITED STATES DISTRICT COURT
NEVADA
February 4, 2011

All emergency department patients were required to be evaluated by the triage nurse and examined by the emergency department physician before being formally admitted to the emergency department.

Just the most basic information, referred to as the Quick Patient Identification, was allowed to be obtained before the patient was seen and treated, and only if time permitted.

That information included only the patient's name, address, phone number, social security number, date of birth and chief complaint.

Basic information could be obtained from a person who accompanied the patient if the patient needed to be taken in directly for treatment.

Only after the patient had been cleared by the physician was the admitting department to be informed of the patient's presence so that the formal admission process could be started.

In this case the hospital violated this patient's rights under the EMTALA by handling her case quite differently than the way other patients' cases were routinely handled, that is, assuming the hospital followed its standard operating procedures with its other emergency room patients. **Abney v. Univ. Med. Ctr., 2011 WL 468349 (D. Nev., February 4, 2011).**

www.nursinglaw.com/mar11pro3.pdf

March 2011

New Subscriptions
See Page 3

Sexual Harassment: Male Aide Failed To Prove His Case Against Female Supervisor, Female Charge Nurse.

A male mental health aide filed a sexual harassment lawsuit against the hospital where he had worked claiming he was sexually harassed by his female supervisor and by a female charge nurse.

The US District Court for the Southern District of Texas accepted the basic premise that a male employee can be considered a victim of sexual harassment by a female supervisor or a female co-worker, but the Court dismissed the case because the evidence was lacking that the hospital violated his rights under the law.

Supervisor

The employee had a month-long sexual affair with his supervisor. He claimed he went along with it because he was afraid of losing his job. He was fired from his job four months after he broke it off.

The Court pointed out that the employee never reported a complaint of sexual harassment until two months after he broke off the relationship, and only after he was in trouble for insubordination and poor attendance. Employees are required to complain at once about sexual harassment, if they want to preserve their rights.

The hospital took prompt action as soon as management became aware of his allegations of sexual harassment. The day he finally voiced his complaint the supervisor was interviewed and admitted having an affair with her subordinate.

Without resolving the issue of consent *versus* lack of consent, the hospital suspended the supervisor that same day so she would not return to work at the facility as the victim's supervisor the next day.

Charge Nurse

The employee's charge nurse admitted she was guilty of making a few isolated crude sexual comments.

The Court ruled, however, that the comments were not serious enough to create a sexually hostile working environment or to alter in a significant way the terms and conditions of the employee's employment. **Giron v. Texas West Oaks Hosp., 2011 WL 486256 (S.D. Tex., February 7, 2011).**

It is possible for a male employee to be considered a victim of sexual harassment by a female supervisor or a female co-worker.

Sexual harassment on the job is a form of sex discrimination that is outlawed by the US Civil Rights Act and state laws.

The charge nurse made several sexually inappropriate comments over the course of seven months.

This falls below the threshold for a successful sexual-harassment lawsuit.

Teasing, offhand comments and isolated incidents are not considered discriminatory.

The employee did not feel threatened or humiliated by the remarks and they did not interfere with his ability to continue working.

As to the supervisor, once hospital management finally was informed of their affair the supervisor was suspended on the spot for having sex with a subordinate.

It is not conclusive that breaking off the affair months earlier had anything to do with his termination.

UNITED STATES DISTRICT COURT
TEXAS
February 7, 2011

Patient's Fall: Fall Precautions Were Not Started Based On Current Assessment.

The seventy-two year-old patient was admitted to the hospital for treatment of heart failure and cancer.

On admission her fall-risk assessment score was 6. Two days later it rose to 8.

Policies at the facility called for fall risk interventions to be started for any patient with a fall-risk score above 6.

The evening of the third day in the hospital the patient's daughter reportedly told the nurse her mother was trying to climb out of bed.

The next morning the patient was found unconscious on the bathroom floor. It was not clear whether she was injured from falling. However, prolonged lack of supplemental oxygen while lying on the floor resulted in the patient never regaining consciousness. She died later that evening.

The patient's fall risk was assessed on a daily basis.

A score above 6 on the risk assessment instrument in use at the facility meant that fall risk interventions were necessary.

When her score rose from 6 to 8 nothing was done.

DISTRICT COURT
ORLEANS PARISH, LOUISIANA
July 6, 2010

The family's case filed in the District Court, Orleans Parish, Louisiana resulted in a $75,000 settlement from the hospital and an additional award by the Court from the state's Patient Compensation Fund.

The nurses should have provided a call light, regularly checked on the patient and discussed restraints with the physician.

The nurses should not have advised the daughter not to stay when the daughter asked the nurses if it was advisable for someone to stay through the night. **Dugas v. Tenet Health, 2010 WL 5663903 (Dist. Ct. Orleans Parish, Louisiana, July 6, 2010).**

Patient's Fall: Nurse Did Not Raise All Four Bed Rails, Court Sees No Nursing Negligence, Suit Dismissed.

The seventy-seven year-old patient was admitted to the intensive care unit for pneumonia.

She had a history of stroke earlier that same year and had difficulty speaking and moving the right side of her body.

The patient's nurses assessed her as a high fall risk. Following hospital policy, the top rails of the bed were raised on both sides of the bed, but the bottom rails were not raised because there was no order from the physician to that effect.

The patient was agitated most of the time during her hospital stay. On the day she fell out of bed she had been having repeated bouts of fecal incontinence in bed which made her all the more agitated. The nurses cleaned her and repeated the sedative ordered by the physician.

The patient was found on the floor with bruising on her face and shoulder. The nurse who found her filled out an incident report in which she indicated that all four bed rails were immediately raised afterward to prevent a recurrence.

The patient died several days later from medical causes unrelated to her fall.

The patient's estate filed a lawsuit against the hospital for nursing negligence. The jury found no negligence and awarded no damages. The Court of Appeals of Wisconsin upheld the jury's verdict.

The patient's nurses are correct that raising all four bed rails would be considered a form of physical restraint which requires a physician's order.

Imposition of a restraint not ordered by the physician is a violation of the patient's right to be free from restraints which are not medically necessary.

Use of all four bed rails can pose risks to the patient.

A patient who wants to get out of bed may try to climb over the rails or be injured while getting caught in the rails.

The two rails on each side of the top of the bed were authorized by hospital policy to be raised without an order because the patient was classified as a fall risk.

All four bed rails could not be raised unless ordered by the patient's physician.

COURT OF APPEALS OF WISCONSIN
February 8, 2011

Nurse Failed to Inform Family They Could Request Bed Rails Raised

The lawsuit alleged the patient's nurses were negligent for failing to notify the patient's husband and son that they could request all the bed rails to be raised.

If they had been so informed, the husband and son claimed in court, they would have requested all the bed rails raised, the physician would have agreed, the rails would have been raised and the patient would not have ended up on the floor.

The Court ruled that legal theory was not a viable basis for a negligence lawsuit against a hospital.

Although this particular hospital did have a policy which allowed family members to be told they could request that a family member's bed rails be raised, the Court found no evidence of a prevailing standard in the hospital industry or standard of nursing practice calling for family members to be advised that they have that option.

The legal doctrine of informed consent to treatment does not stretch so far as to require physicians or nurses to provide this information, the Court ruled.

Nurse's Statement in Incident Report

The nurse's statement in the incident report that all four rails were raised after the incident was also no legal basis for a negligence lawsuit against the hospital.

As a general rule, taking corrective measures after an incident does not prove it was negligent not to have taken the same measures before the incident. **Estate of Brown v. Physicians Ins. Co., 2011 WL 383792 (Wis. App., February 8, 2011).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924

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

EMTALA: E.R. Triage Nurse Followed Hospital's Procedures, Patient's Lawsuit Dismissed.

The parents brought their seven year-old son to the emergency room.

The triage nurse saw the boy at 7:39 a.m. and took vital signs, temp 98.1, BP 110/67 and heart rate 145. The elevated heart rate led the nurse to classify him as a potential emergency patient. She put him in a room to be seen by the physician.

The physician saw him at 8:00 a.m. The parents told him the boy had been vomiting during the night. The physician ordered a CBC. The CBC band count and manual differential, which were available on the computer at 9:35 a.m. showed evidence of an ongoing infection.

The triage nurse took vitals at 9:58 a.m. The heart rate was down to 105-110. The physician, without looking at the lab results, discharged the patient at 10:15 a.m.

The next morning the child was brought back and had to be airlifted to another hospital in septic shock.

Triage Nurse Did Not Depart From Hospital Procedures Or Violate Patient's EMTALA Rights

The hospital's triage nurse saw the patient promptly, assessed him, classified him as a potential emergency case and had him seen promptly as such by the emergency department physician.

The hospital's E.R. guidelines for pediatric patients with vomiting/diarrhea/dehydration allowed, but did not require the triage nurse to order lab tests, including CBC and urinalysis when the child could not be seen right away by a physician.

The guidelines, however, did not establish a standard E.R. screening policy. They were intended only to improve patient flow and applied only when the pediatric patient could not be seen promptly by the E.R. physician. According to the US Court of Appeals for the Fifth Circuit, the hospital's guidelines did not place the responsibility on the triage nurse to order testing that was not ordered by the physician, as the parents' lawsuit argued.

The nurse did take vital signs within one hour before the child was discharged, as required by hospital policy. **Guzman v. Memorial Hermann, 2011 WL 303260 (5th Cir., February 1, 2011).**

Congress enacted the Emergency Medical Treatment and Active Labor Act (EMTALA) to prevent "patient dumping," that is, hospitals refusing to treat emergency room patients who are uninsured or unable to pay.

Any individual who comes in for emergency care is entitled to an appropriate medical screening examination and stabilization of an emergency condition.

An individual who is not stabilized can be transferred elsewhere for treatment only if stringent conditions are met.

An appropriate screening examination is the same screening examination the hospital would offer to any other patient in a similar condition with similar symptoms.

A patient can prove disparate treatment by showing that the hospital did not follow its own standard screening procedures or by pointing to differences between the screening examination that the patient received and the examinations that other patients with similar symptoms received at the same hospital.

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT
February 1, 2011

Labor & Delivery: Nurse Faulted For Mishandling Of Shoulder Dystocia.

The baby's delivery was performed in the hospital by an obstetrician with the assistance of a registered nurse.

The child now has Erb's palsy as a result of complications from her delivery during which shoulder dystocia was encountered and allegedly mishandled by the obstetrician and nurse.

A lawsuit was filed on the child's behalf against the obstetrician and the nurse. The nurse's lawyers asked for dismissal of the nurse from the case on the grounds that the parents' lawyers had not come up with a valid opinion from an expert to support their allegations of nursing negligence.

When shoulder dystocia is encountered during delivery the labor and delivery nurse has a duty to advocate for the patient.

The nurse must immediately call for assistance from additional qualified medical staff including a neonatologist and an anesthesiologist and additional nurses, if available.

APPEALS COURT OF MASSACHUSETTS
February 8, 2011

The Appeals Court of Massachusetts ruled that the opinion from the family's expert pointed to nursing negligence.

Shoulder dystocia can require the McRoberts Maneuver to free the impinged shoulder, and that requires the involvement of more people, all of whom have to be knowledgeable and qualified, optimally three more than the two, the ob/gyn and the nurse who were there for this delivery.

The nurse also has to document that shoulder dystocia was encountered and what was done about it. That documentation was absent in this case. **Donaldson v. Payne, 2011 WL 383036 (Mass. App., February 8, 2011).**

Skin Care: Two Sets Of Medical Records, Jury Awards Damages.

The sixty year-old patient was admitted to the nursing home from the hospital with congestive pulmonary failure, pulmonary edema, diabetes and nephritic syndrome.

Due to immobility and generally poor health she was at increased risk for breakdown of skin integrity. When she came to the facility she already had a Stage II sacral bedsore that apparently had started in the hospital.

After a month in the nursing home she had to be transferred back to the hospital with a Stage IV lesion which healed after treatment in the hospital.

The patient's lawyers had two copies of the chart, one obtained before the lawsuit was filed and another obtained during the lawsuit.

The second chart, but not the first, seemed to show that the patient actually was being repositioned every two hours.

DISTRICT COURT
QUEENS COUNTY, NEW YORK
August 26, 2010

The jury in the District Court, Queens County, New York awarded the patient $305,000 from the nursing home and nothing from the hospital.

The nursing home should not have accepted a difficult patient with a Stage II sacral lesion if the facility was not able to meet her needs.

Nursing care flow sheets in the chart were apparently rewritten retroactively after the lawsuit was in progress to show that q 2 hour repositioning was being done. The patient's lawyers were allowed to show both sets of records to the jury and invite the jury to come to the conclusion that proper care was not being performed. **Questelles v. Highland Care Center, 2010 WL 5760852 (Dist. Ct. Queens Co, New York, August 26, 2010).**

Child Abuse: E.R. Nurse Who Reported Is Cleared Of Parents' Allegations Of Wrongdoing.

Healthcare providers must take action when child abuse is suspected. It is a crime to fail to do so.

There must be an immediate verbal report to child protective services or to local law enforcement.

A mandatory reporter of child abuse is immune from being sued for making a report, assuming the reporter did not make the report maliciously or in bad faith.

The immunity covers the act of reporting as well as the diagnoses or other impressions or conclusions expressed in the report.

If sued, a mandatory reporter does not have to prove he or she acted in good faith.

Bad faith or malice must be proved by the party who filed the lawsuit.

The burden of proof is not on the mandatory reporter.

The healthcare provider is under no legal duty to believe or give any credit to a parent's explanation of possible signs of child abuse.

A healthcare provider, a nurse for example, is not required to involve a physician in the decision to report or the report itself.

UNITED STATES DISTRICT COURT
INDIANA
January 25, 2011

The preschool teacher called child protective services about a child who seemed to have a vaginal infection.

A worker from child protective services told the child's mother to take the child to the E.R.

A nurse practitioner in the E.R. found a vaginal tear that she believed could have been caused by digital penetration. The child would not talk to her about how it happened.

The nurse practitioner related what she found to the child protective services worker. The nurse practitioner later admitted the tear could have been caused by the child having an infection and scratching herself.

However, the fact of the injury and the strong suspicion of sexual abuse required the nurse practitioner to report what she found, even if the diagnosis was not absolutely conclusive.

The nurse practitioner did not share her findings or impressions, one way or the other, with the mother. Nor did she contact the child's doctor or recommend the mother contact the doctor for an evaluation and a second opinion. She was not required by law to do either of those things.

Charges of child abuse were sustained against the father who is now a registered sex offender.

The mother and father sued the preschool teacher, the case worker and the nurse practitioner. The United States District Court for the Northern District of Indiana dismissed their case.

Nurse Practitioner
Mandatory Reporter

The E.R. nurse practitioner was required to report her findings candidly to child protective services. She would have been guilty of a crime if she did not.

There was no evidence of conspiratorial intent on her part as was alleged in the parents' lawsuit. The parents had the burden of proof to prove bad faith. The nurse practitioner did not have to prove she acted in good faith to escape liability in the lawsuit. **Massenberg v. Richardson, 2011 WL 294843 (N.D. Ind., January 25, 2011).**

Home Health: Settlement Paid To Nurse Injured In Home Of Patient.

A home health nurse was exiting her client's home carrying a laptop computer and a bag of equipment and supplies when she tripped and fell.

The storm door was incorrectly installed with no bottom sill, according to the expert hired by the nurse's attorney to testify on her behalf if the case had had to go to trial in the District Court, Racine County, Wisconsin.

She broke her ankle and later needed to have surgery on her hip.

A large portion of the $400,000 settlement went to reimburse the nurse's agency's workers compensation insurer which had paid her medical expenses and lost income. **Haase v. Beardsley, 2010 WL 5650210 (Dist. Ct. Racine Co., Wisconsin, September 28, 2010).**

Post Surgical Care: Settlement Paid To Patient's Family.

The twenty-nine year-old patient was transferred to a med/surg floor four hours after thyroidectomy surgery.

She began having shortness of breath. Her condition worsened from inability to breathe to respiratory arrest, cardiac arrest, hypoxic encephalopathy and death.

The family's lawsuit filed in the Superior Court, Pierce County, Washington faulted the surgeon for the post-operative bleeding into the patient's airway.

The lawsuit also faulted the nurses for requesting the E.R. physician to come to the room rather than calling a code.

The nurses reportedly waited to call the E.R. physician for help until they had completed a full patient assessment while the patient was already in acute respiratory distress from a known possible complication of the surgery she had just had. **Hayward v. Multicare, 2010 WL 5691874 (Sup. Ct. Pierce Co., Washington, September 3, 2010).**

Fall: Aide Was Not Negligent, Jury Says.

The patient was admitted to the day surgery unit for a lumbar laminectomy.

While going from a sitting to lying position on a hospital gurney the patient fell off, hit the floor and sustained a rotator cuff injury.

The patient's lawsuit claimed the hospital failed to appreciate his fall risk factors, that is, prior back surgeries, problems with mobility and depression and failed to devise and implement a fall-care plan.

The aide caring for the patient testified the patient suddenly flung both his legs up onto the gurney without being so instructed, and that was how and why he fell.

The jury in the Superior Court, King County, Washington decided that the patient's own negligence was the cause of the accident and awarded no damages. **Schweikl v. King Co. Hosp. Dist., 2010 WL 5624418 (Sup. Ct. King Co., Washington, December 2, 2010).**

Cardiac Patient: Nurse Complied With Standard Of Care.

The jury had to decide whom to believe.

The outpatient clinic nurse testified the patient came in for chest pain and a cough. With those symptoms and a pulse of 145 the nurse told him and his wife he needed to go to the emergency room. Her chart note was, "pt. non-compliant."

The patient's wife testified they were told to come back the next day for blood tests, then to come back again because he had been fasting too long.

The patient only went to the E.R. a week later and was diagnosed with atrial fibrillation, heart attack and stroke. No delay in treatment could be blamed on the clinic nurse, the Court of Appeals of North Carolina ruled. **Davis v. Rudisill, 2011 WL 532403 (N.C. App., February 15, 2011).**

Labor & Delivery: Faulty Nursing Assessment Before Induction Of Labor.

The labor and delivery nurses' vaginal exam when the mother was admitted seemed to reveal the baby was in a head-first presentation.

Her ob/gyn physician, who had done all of her prenatal exams, ordered Cytotec at 7:00 p.m. and again at 11:00 p.m. to move the labor along, without actually coming in to see the patient.

At 2:10 a.m. the nurse saw meconium on the bed sheet. The nurse did a vaginal exam and could not verify the baby's presentation. The nurse paged the ob/gyn. The ob/gyn came in, examined the patient and determined it was a breech presentation. The heart tones were non-reassuring. He started an emergency c-section at 3:00 a.m. The baby died several weeks later.

The nurses started medication to induce labor without an accurate assessment that the baby was in a cephalic presentation and before the fetal monitor was started and reassuring data was obtained.

COURT OF APPEALS OF TEXAS
February 15, 2011

The Court of Appeals of Texas saw grounds for the parents' lawsuit.

Before a labor-inducing drug is started it must be determined the baby is in a head-down presentation, by means of a vaginal exam or an ultrasound, and assessment of the presentation should continue until the baby is delivered. Reassuring monitor data should be obtained before starting the medication, the parents' experts also said.

The nurses' assessment was faulty and the ob/gyn was negligent to rely on the nurses' assessment without verifying it himself, the Court believed. **Herrera v. Holiday, 2011 WL 531694 (Tex. App., February 15, 2011).**

Blood Therapies: Jury Finds Nurses Not Negligent.

The fifteen year-old patient was diagnosed with thrombotic thrombocytopenic purpura and began periodic plasmapheresis treatments at the hospital.

The patient's condition is generally recognized as fatal without treatment. Plasampheresis treatment itself does involve an approximately 3% risk of an anaphylactic reaction.

The patient was admitted to the hospital fourteen months after her initial diagnosis. Plasmapheresis was attempted twice but both times resulted in anaphylactic reactions.

After several days the patient's hemoglobin dropped to 4.1. The physician ordered packed red cells which raised the hemoglobin to 6.2, but it soon fell back again to 4.1. A second transfusion was ordered and promptly started by the nurses, but the patient coded and died soon after the red cells were hung.

The patient's nurses obtained the blood draws that were ordered by the physicians, promptly communicated the lab results to the physicians and started the last transfusion promptly after it was ordered.

CIRCUIT COURT
ORANGE COUNTY, FLORIDA
October 4, 2010

The jury in the Circuit Court, Orange County, Florida found no negligence by the hospital's nurses.

The nurses did everything they could have and should have done to stay on top of the patient's critically low hemoglobin. They obtained the blood draws ordered by the physicians, kept the physicians informed of the lab results and obtained and hung the last transfusion of packed red blood cells when it was ordered.

The pediatric hematologist/oncologist reportedly did pay a confidential settlement to the parents. **Acevedo v. Orlando Regional Healthcare, 2010 WL 5781189 (Cir. Ct. Orange Co., Florida, October 4, 2010).**

Medicaid: New Regulations Will Bar Payments For Health Care-Acquired Conditions.

We have CMS's announcement from the Federal Register on our website at http://www.nursinglaw.com/CMS021711.pdf

The new Medicaid regulations are set to take effect on July 1, 2011.

CMS will accept comments from the public until March 18, 2011.

The new regulations are in response to the healthcare reform bill enacted last year, known as the Patient Protection and Affordable Care Act of 2010.

The goal, according to CMS's announcement, is to provide care and services in the best interests of beneficiaries and to provide payment that is consistent with efficiency, economy and quality of care.

To prevent loss of beneficiaries' access to care, reduction in payments are to be limited by state Medicaid plans to the amounts directly related to the provider-preventable condition and the resulting treatment.

That means, for example, that if a patient develops an infection after surgery, payment would be denied for the post-surgical infection but not for the surgical procedure itself.

FEDERAL REGISTER February 17, 2011
Pages 9283 - 9295

On February 17, 2011 the US Centers for Medicare and Medicaid Services (CMS) published proposed new regulations that will bar payment under Medicaid for treatment of health care-acquired conditions.

The list of health care-acquired conditions for Medicaid non-payment is basically the same as that already in effect for non-payment under Medicare:

Foreign object retained after surgery
Air embolism
Blood incompatibility
Falls and trauma
- Fractures
- Dislocations
- Intracranial injuries
- Crushing injuries
- Burns
- Electric shock

Manifestations of poor glycemic control
- Diabetic ketoacidosis
- Nonketotic hyperosmolar coma
- Hypoglycemic coma
- Secondary diabetes with ketoacidosis
- Secondary diabetes / hyperosmolarity

Catheter-Associated urinary tract infection
Vascular catheter-associated infection
Surgical site infection following
- CABG - mediastinitis
- Bariatric surgery
- Laparoscopic gastric bypass
- Lap gastric restrictive surgery
- Orthopedic procedures / spine / neck
  shoulder / elbow

Deep vein thrombosis or
Pulmonary embolism following
- Total knee replacement
- Hip replacement

Individual states will have the flexibility to expand the list of provider-preventable conditions for which payment will not be made under Medicaid. Some states already have non-payment regulations in place. CMS's new regulations provide a baseline Federal standard.

FEDERAL REGISTER February 17, 2011
Pages 9283 - 9295

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Understaffing: Large Verdict Against Nursing Home.

When the seventy-six year-old patient was admitted to the nursing home for rehab the goal was that her stay would allow her to regain her strength so that her children would again be able to care for her in her home.

Two weeks into her stay she fell and sustained closed-head trauma and a fractured arm. Then she developed multiple bedsores, dehydration, malnutrition and contractures. The family removed her from the facility two months after admission and she died six weeks after that.

The family's lawsuit in the Circuit Court, Polk County, Florida focused on the business practices of the nursing home's parent corporation which allegedly stressed expansion and growth over quality of patient care. A number of direct-care staff were reportedly brought in as witnesses to testify about terrible conditions brought on by chronic understaffing and shortages of supplies.

The jury's verdict, including punitive damages, was $114,000,000. **Jackson v. Briar Hill, 2010 WL 5781222 (Cir. Ct. Polk Co., Florida, July 20, 2010).**

Understaffing: Large Verdict Against Nursing Home.

His wife could no longer take care of him at home after a stroke a few months earlier. The patient also had cancer and had a feeding tube had been inserted into his stomach.

The ninety-two year-old patient died nine days after admission to the nursing home. A state investigation revealed he was severely dehydrated and malnourished and had very quickly developed infected bedsores before he died.

With a feeding tube it would have been relatively easy to provide sufficient fluid intake. However, there was reportedly no documentation of fluid intake being monitored.

The family's lawsuit in the Circuit Court, Hopkins County, Kentucky focused on the nursing home's parent corporation's business practices. Allegedly the patient was admitted because he was a high-acuity Medicare patient, not because the facility planned to and was able to meet his needs.

The jury verdict, including punitive damages, was $40,750,000. **Offutt v. Harborside, 2010 WL 5790973 (Cir. Ct. Hopkins Co., Kentucky, November 16, 2010).**

Skin, Foley Care: Suit Alleges Understaffing, Large Settlement Paid By Rehabilitation Facility.

The deceased patient's family's lawsuit in the Superior Court, San Diego County, California contended that the rehab facility where the patient was admitted after a fall at home was chronically understaffed to the point that even the patient's most basic needs could not be met.

The patient developed a closed blister on his right heel which the nurses classified as a Stage II pressure ulcer. While the lesion progressed to an open gangrenous wound little was done. The facility's policy was that progression of a skin lesion's staging required a new physician consult and updated treatment orders and nursing care plan.

When he got to the hospital for the skin lesion it was discovered that neglect of his Foley catheter had caused major erosion of the surrounding tissue.

The facility's policies and procedures called for the nurses to obtain a physician consult and reconsider the care plan when the staging of a patient's pressure lesion progressed.

They continued to treat a lesion as a Stage II pressure ulcer after it had progressed to an open gangrenous wound with dark brown eschar surrounding red tissue.

SUPERIOR COURT
SAN DIEGO COUNTY, CALIFORNIA
October 11, 2010

It was apparent that daily inspection of the Foley site by a licensed nurse and appropriate cleansing had never been done, despite documentation in the chart that it had been done.

A nurse testified that nurses were too busy to give the care that was needed and often would simply chart appropriate care that was not done.

The family's lawyers were prepared to argue that the facility's parent corporation knew the facility was understaffed to the point that staff were too busy to care for their patients but failed to implement funding so that appropriate levels of staffing could be maintained.

The family's lawsuit was settled for a total payment of $1,000,000. **Shulkin v. Point Loma, 2010 WL 5781053 (Sup. Ct. San Diego Co., California, October 11, 2010).**