

LEGAL EAGLE EYE NEWSLETTER

May 2007

For the Nursing Profession

Volume 15 Number 5

ICU Nursing: Death Of Patient Post-CABG Surgery Tied To Substandard Nursing Care.

The patient was sent to the hospital's intensive care unit (ICU) after coronary artery bypass graft surgery (CABG).

The physician's post-operative orders specified one-to-one nursing care in the ICU.

The patient was on an intra-aortic balloon pump, a medical device implanted in the operating room inside the distal arch of the descending aorta through an opening in the femoral artery, connected to a driving Helium gas pump designed to pulse on at diastole and off at systole in synchronization with set points in the patient's EKG waveforms, the overall goal being to assist cardiac recovery by lessening myocardial systolic oxygen demand.

At 1:00 a.m. the patient's ICU nurse astutely picked up on the fact the pump was not functioning correctly. She immediately called the cardiologist. The cardiologist ordered the balloon promptly removed from the patient's body by a trained radiology tech.

However, two hours after the pump was removed the patient bled profusely at the insertion site, coded, could not be revived and remained in a coma until he died. The coroner ruled the cause of death anoxic encephalopathy secondary to external blood loss.



The court accepts the testimony of the patient's nursing experts that one-to-one nursing care in the ICU means the nurse must remain at the patient's bedside unless relieved by another one-to-one nurse.

An ICU nurse assigned to provide one-to-one care cannot leave the patient's bedside at a critical moment to restock supplies in the linen closet.

COURT OF APPEAL OF LOUISIANA
April 4, 2007

The Court of Appeal of Louisiana threw out the jury's verdict exonerating the hospital from blame as "clearly wrong and manifestly erroneous" and ordered the hospital to pay more than \$500,000 to the surviving spouse and children.

One-To-One ICU Nursing Care

An hour after the balloon was removed through the femoral artery, about a half hour after the arterial wound seemed to have stopped bleeding after more than thirty minutes of manual pressure, the patient's systolic blood pressure abruptly dropped almost sixty points.

The patient's ICU nurse did not think the sudden blood-pressure drop meant anything was wrong, did not notify the cardiologist or a staff physician and left the patient's bedside to re-stock supplies in the linen closet near the nurses station, according to the court record.

The nurse was called back to the patient's bedside after an eighteen minute absence by the sounding of the EKG alarm, after the patient had already bled out into the bed.

The court began its review of the multiple nursing-liability issues in the case by deciding to accept the family's nursing experts' definition of one-to-one nursing care in a hospital intensive care unit and to discount the hospital's experts' views.

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EMTALA: Court Says Nurse Practitioner Properly Discharged ER Patient.

Based on her pediatrician's advice, the mother took her young son to the hospital's emergency room.

They had been to a different hospital's emergency room just three hours earlier where the boy's complaints of lower right quadrant pain were dismissed, with no diagnostic tests having been done, as nothing more than acute gastritis.

CT Done for Appendicitis Apparently Normal Patient Sent Home

At the second hospital a nurse practitioner suspected appendicitis. He saw to it that a CT scan was done and read by the radiologist on call. The nurse practitioner called the radiologist for confirmation that the appendix was not an issue and then sent the boy home with pain medication.

The next day another radiologist and the pediatrician reviewed the CT and believed it was positive for acute appendicitis. At the same time the boy's symptoms had gone from bad to worse and the mother brought him back to the first hospital for an appendectomy to remove his ruptured appendix.

No EMTALA Violation

The US District Court for the Western District of Louisiana ruled the hospital where the CT was done did not violate the US Emergency Treatment and Active Labor Act, but expressly left open the question whether the on-call radiologist committed malpractice, a separate legal issue from the EMTALA.

The essence of the EMTALA is that every emergency room patient with the same presenting signs and symptoms must receive the hospital's same predefined emergency medical screening and stabilizing care before being discharged.

Any other patient at the same hospital with symptoms suggesting appendicitis would have been sent home after an apparently normal CT, the court said. **Spillman v. Southwest Louisiana Hospital Assn., 2007 WL 1068489 (W.D. La., April 4, 2007).**

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

The EMTALA requires a hospital which has an emergency department to provide an appropriate medical screening and necessary stabilizing treatment and restricts an unstabilized patient being transferred to another facility unless that will provide needed care that is not available at the hospital.

An appropriate medical screening is the same medical screening that would be provided to any other patient with the same signs and symptoms.

That is, to sue a hospital for violating the EMTALA, a patient must show that he or she was treated differently than other patients coming to the ER with the same signs and symptoms.

Whether or not the emergency medical screening was done negligently is not the focus of the EMTALA.

UNITED STATES DISTRICT COURT
LOUISIANA
April 4, 2007

Cunningham Clamp: Facility Faulted For Inadequate Patient Teaching.

The forty-one year-old male patient was paraplegic from an old gunshot wound. He resided in an extended-care nursing facility.

After treating him for decubitus ulcers his physician decided to supplant his condom catheter with a Cunningham clamp, a metal and foam-rubber device which clamps the penis to control male urinary incontinence.

The physician ordered the clamp from a medical supplier to be delivered directly to the nursing facility.

The clamp arrived at the facility and was issued directly to the patient. The physician phoned two days later and informed the nursing staff that the clamp had to be removed at least q 2 hours.

The Cunningham clamp was issued directly to the patient by the facility's nursing staff without any patient teaching, that is, without the patient being instructed that it had to be taken off at least every two hours and kept off for at least a half hour to avoid damage to the penis.

SUPREME COURT, KINGS COUNTY
NEW YORK
March 6, 2007

The damage was already done. The patient obtained a settlement of \$500,000 from the nursing home's insurance company before his case was scheduled for trial before the Supreme Court, Kings County, New York. **Biggs v. Greenstein, 2007 WL 912188 (N.Y. Supp., March 6, 2007).**

Cerebral Palsy: Patient Drowns In Bathtub In Developmental Center.

The patient had lived in the state-operated developmental center for more than forty-two years before her death.

She suffered from life-long cognitive deficits related to cerebral palsy.

Her caregivers knew, or were supposed to know, she was not to be left unattended in the bathtub, but a treatment aide left her alone in the tub and she drowned.

The state, as her employer, was responsible for the aide's personal errors and omissions as a state employee. A failure was alleged by supervisory staff to train and supervise the aide in her caregiving duties. There were also allegations of violations of the state codes mandating a reasonably safe and hazard-free environment in long-term care settings.

The family's lawsuit against the State of Oklahoma filed in the Oklahoma County District Court was settled for \$135,000. Ferry v. State of Oklahoma, 2007 WL 632739 (Okla. Dist., January 24, 2007).

Patient Assault In Long Term Care: Facility Held Liable.

A seventy year-old female Alzheimer's patient was sexually assaulted by an eighty-three year-old male Alzheimer's patient. Both resided in the same long-term care facility. The victim died of unrelated medical causes before the family's case went before a civil jury in the Circuit Court, Duval County, Florida.

Foreseeability is the Key

In this type of legal case, liability for negligence hinges on proof the facility had reason to expect violent or assaultive behavior, and, having grounds to anticipate a problem, failed to take appropriate measures to prevent harm to other residents.

This perpetrator had struck nurses, pinched their buttocks and threatened to stab them. According to the expert testimony heard by the jury, once the perpetrator showed such dangerous behavior he should have been discharged from the nursing home and placed in a secure psychiatric setting.

The perpetrator, in fact, had an extensive criminal history which included two convictions for sex-related offenses. His criminal background, however, was completely excluded from the jury's hearing by the judge on the grounds it would be overly prejudicial. Nevertheless, the jury returned a verdict of \$750,000 for the family against the nursing home. Estate of Thurston v. Southwood Nursing Center, 2007 WL 866450 (Fla. Cir. Ct., February 22, 2007).

Elopement: Psych Patient's Family Awarded \$12,000,000 For Wrongful Death.

A mental health assistant took ten patients to the hospital's psychiatric floor's outside deck. One of the patients climbed the 12-foot iron fence, fell 25 feet to the top level of the parking garage, crawled badly injured 100 feet to the edge of the top level of the garage and then fell another 80 feet to his death.

Fence Could Be Climbed

The 12-foot-high wrought-iron fence had iron cross bars that made it as easy to climb as an ordinary ladder.

The fence was a liability issue primarily for the hospital's architects and facilities managers. However, the fence being so easy for a patient bent on elopement or self-harm to climb also made it a liability issue for nursing caregivers in that one aide for ten patients was not adequate supervision, the family's attorneys argued to the jury in the Circuit Court, Jefferson County, Alabama.

No Emergency Response Plan

The family's lawyers also argued that the facility should have had an emergency response plan to have allowed the aide to summon and get help right away.

One nurse who happened to see what happened went to the patient's aid on the parking garage but was not able to stop the second fall which actually killed him. Estate of Hollon v. Brookwood Medical Center, 2007 WL 912202 (Ala. Cir. Ct., February 15, 2007).

LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

ISSN 1085-4924

© 2007 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.

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Unrestrained Stroke Patient Falls From Bed: Jury Rules Caregivers Not Negligent.

The seventy-four year-old patient had to be admitted to a hospital after her third stroke, a massive event which left her completely paralyzed on her right side.

After the hospital did all it could the patient was discharged to a nearby skilled nursing facility.

Hospital Discharge Indicated Occasional Use of Restraints

The evidence presented at trial in the Superior Court, Los Angeles County, California, included the patient's discharge summary from the hospital.

The discharge summary made reference only to "occasional" use of restraints in the hospital. "Regular" or "usual" use of restraints checked off on the discharge form would have put the nursing facility on notice of a potentially high fall risk.

The faulty data in the discharge summary was contradicted by testimony at trial that a Posey vest was used regularly in the hospital. However, that fact was not communicated to and was not known by the staff at the skilled nursing facility prior to the patient falling out of bed.

Close Monitoring After the Patient Fell

A CNA heard the patient fall out of bed at 2:00 a.m. and right away told the nurse. She checked and found a medium-sized bump on the patient's head, phoned the physician a little after 2:00 a.m. and he ordered hourly nursing neuro assessments.

After four such assessments, at about 7:30 a.m., the nurse phoned the physician, concerned the patient could not be roused. The physician sent her to the hospital for a CT scan which was delayed getting a family member's consent.

The patient had a subdural hematoma. The physicians deemed her injury untreatable and she was returned to the nursing facility and allowed to pass.

After looking at the pre-fall assessment and quick post-fall response, the jury found no negligence in the care given by the nursing facility. **Simon v. Sierra Madre Skilled Nursing**, 2007 WL 685830 (Cal. Super., February 9, 2007).

The patient's nurse did not complete the fall-risk assessment between the time the patient was admitted to the skilled nursing facility and when she fell.

However, had the fall-risk assessment been completed, the nursing assessment would have been that the patient, with complete right-side paralysis, was a low fall risk.

If the fall-risk assessment had been done and communicated to the facility's interdisciplinary team, the team would have recommended to the patient's primary-care physician not to write an order for restraints.

The overall treatment goal was to use the lowest level of restraint necessary for the patient, that is, to raise the bed rails or take other measures rather than impose a Posey vest while the patient was in bed.

After she fell, the patient was promptly and competently assessed and cared for by her nurses and her physician was promptly informed of the situation.

The facility was not negligent.

SUPERIOR COURT, LOS ANGELES COUNTY
CALIFORNIA
February 9, 2007

Patient Falls: Family Obtains Settlement.

The eighty-eight year-old Alzheimer's patient was living in a nursing home.

He fell out of bed. The staff of the nursing home were not aware he had fallen until another resident happened to walk by his room, saw him on the floor and notified the staff nurse on duty.

The nurse just put the resident back to bed without a physical exam or nursing neurological assessment for signs of a closed head injury. The patient, of course, was not able to verbalize meaningful complaints of injury.

Almost a week later he began to show unmistakable signs of a head injury. The nursing staff had him taken to the hospital. He died from a closed-head injury after five days in the hospital.

The family's lawsuit alleged negligent failure to supervise the resident.

That is, whether or not the facility was negligent for allowing him to fall out of bed, after they knew he had fallen no effort was made to assess the nature and extent of his injuries.

SUPERIOR COURT, SAN MATEO COUNTY
CALIFORNIA
January 2, 2007

The family's lawyer was prepared to put a medical expert on the witness stand to testify that the patient's subdural hematoma could have been successfully treated surgically, that is, if the physicians had been able to take action right away.

Prompt medical treatment, however, would have been possible only if there had been a prompt and competent nursing assessment of his injuries.

The family obtained a \$300,000 settlement. **Cox v. (Name Withheld – Confidential) Nursing Facility**, 2007 WL 686055 (Cal. Super., January 2, 2007).

Sign-Language Interpreters: Court Says Deliberate Indifference Required For Patient To Sue.

When it appeared the patient's hearing teenaged children could not sign well enough for their deaf father to communicate with his medical caregivers, the hospital's speech and hearing department began phoning qualified interpreters on their list but were not able to get one to come in right away on a Friday afternoon.

Hospital personnel made a good faith effort to locate a sign language interpreter.

A hearing-impaired patient can sue only if the hospital has been deliberately indifferent to the patient's need for interpretive services.

It proves nothing when a hospital acknowledges its practices can stand improvement and implements changes after the fact.

UNITED STATES DISTRICT COURT
NEW YORK
February 27, 2007

The US District Court for the Eastern District of New York pointed to the myriad state and Federal statutes which require healthcare facilities to offer interpretive services for hearing impaired patients.

However, a patient, to be able to sue, must show that an unfulfilled request for an interpreter resulted from the medical facility's deliberate indifference, a difficult legal burden of proof for the patient. Loeffler v. Staten Island University Hosp., 2007 WL 805802 (E.D.N.Y., February 27, 2007).

ICU Nursing: Death Of Patient Post-CABG Surgery Tied To Substandard Nursing Care.

(Continued from page 1)

One of the patient's family's nursing experts testified that if a nurse has been assigned to care for a patient on a one-to-one basis, the nurse is not allowed to leave the patient's bedside at any time without asking a colleague to take over the patient's care in the nurse's absence. The court accepted this as a correct statement of the legal standard of care.

One of the hospital's nursing experts, whose testimony the court discounted, testified that the American Association of Critical Care Nurses (AACN) Procedural Manual for Critical Care does not define the phrase one-to-one nursing and, therefore, does not set a legal standard that a critical-care nurse is never allowed to leave the patient's bedside. It means only that the nurse has only one patient to care for, but does not necessarily mean the nurse must stay at the bedside, the hospital's expert testified.

The court seemed to have been especially disturbed that the patient's nurse had left the bedside of a critical-care patient for some eighteen minutes to re-stock supplies in the linen closet and was at the nurses station when she was called back to the bedside by the sounding of the patient's EKG alarm.

Drop In Patient's Blood Pressure

The nursing experts also disagreed whether a sixty-point drop in an ICU patient's systolic pressure necessitates the physician being notified immediately.

The court elected to accept the patient's family's expert's opinion that a significant drop in blood pressure is a significant change in health status that has to be reported immediately, especially with the patient showing signs of confusion and agitation starting the same time the drop in blood pressure was first seen.

The patient just having had a procedure involving a pencil-sized aperture in a

major artery, the possibility of bleeding at the site should have been considered.

The court disregarded the hospital's expert's opinion that such a drop in blood pressure is only one factor to consider in an overall assessment of the patient's status and should be charted but does not necessarily have to be reported to the physician immediately. The nurse did apparently check the dressing, found no evidence of bleeding and found a pedal pulse, which she believed was ample reassurance the patient was not in immediate jeopardy.

PTT – Balloon Pump Removal

One of the family's nursing experts testified that a partial thromboplastin test (PTT) should have been done before the balloon pump was removed.

The expert went on to say that it is a critical-care nursing responsibility to advocate with the physician for a PTT and/or other laboratory assessment of the patient's blood-clotting ability, especially given the fact he had recently had a CABG.

Wound-Closure Pressure

The same nursing expert testified that when an arterial wound such as the one in this case is closed, it is a nursing responsibility to make note and to document the time it takes for direct manual pressure applied to the wound site to stop, or to appear to stop, the bleeding.

The longer it takes is a factor to be considered by nursing and medical caregivers in assessing further bleeding as a potential complication.

The hospital's nursing expert conceded the standard of care requires direct manual pressure to be continued for thirty to forty-five minutes, but denied there is any accepted standard of care for the critical-care nurse to chart exactly how long it takes. Newson v. Lake Charles Memorial Hosp., __ So. 2d __, 2007 WL 983266 (La. App., April 4, 2007).

Labor & Delivery: Newborn's Cerebral Palsy Tied Directly To Nursing Negligence.

A significant case from the Superior Court, Riverside County, California, was reported on the stipulation that the names of the defendant hospital and doctor be kept confidential.

The case resulted in a \$2.75 million settlement for an infant with brain injuries suffered at birth.

Fetal Heart Rate Monitoring

Fetal heart rate monitoring began upon the mother's non-emergent planned admission to the hospital's labor and delivery department.

The first monitor tracings were entirely within accepted limits, seeming to indicate the fetus was healthy and that a normal vaginal delivery could be anticipated.

A few hours after admission the monitor began to show that decelerations were occurring after the mother's uterine contractions. Fifteen minutes later it became unmistakable that the changes in the fetal heart rate after the contractions were late decelerations with diminished long term variability.

The nurses, however, did not attempt to notify the physician, who had apparently left the hospital and returned to his office.

Twenty minutes later, with the late decelerations continuing, the fetal heart rate rose from 145 to 150, then, following a severe variable deceleration, the heart rate fell to between 60 and 100 and remained in that range for seven minutes. The mother's uterus became hypertonic with contractions lasting five minutes.

Still, the nurses made no attempt to contact the physician. Nor were preparations begun in anticipation of an emergency c-section.

When the nurses did actually contact the physician, at first they did not relay to him the seriousness of the situation nor did they request that he return to the hospital immediately.

Nurse's Legal Duty to Contact Physician And Report Accurate Information

The nurses did not relay the true seriousness of the situation to the physician until more than an hour had elapsed since the nurses were first able, or should have been able, to confirm variable late decelerations from the fetal heart monitor.

By the time the physician was called this time the fetal heart rate had dropped to 60 beats per minute.

Nurses' Legal Duty to Anticipate Emergency C-Section

When the physician did arrive back at the hospital, the mother was taken promptly into an operating room for an emergency c-section.

However, due to lapses in judgment by the attending labor and delivery nurses, a pediatrician and a neonatologist had not been summoned ahead of time and did not arrive until eight minutes after delivery.

Intubation of the newborn had to be attempted by one of the nurses. The nurse erroneously inserted the endotracheal tube into the baby's stomach. Misplacement of the tube compounded the serious deprivation of oxygen the baby had already experienced in the uterus prior to delivery.

The newborn was ventilated with a bag mask and airlifted to the neonatal intensive care unit at another hospital. However, by then the damage was already done.

The child, almost seven years old at the time of the substantial out-of-court settlement, suffered from cerebral palsy, mental retardation and spastic quadriplegia.

One mitigating factor, argued on behalf of the defendant hospital and physician, was that the child would never need the projected \$11 million for a lifetime of special care if he lived to a normal life expectancy, because he was not expected to survive beyond childhood. Wert v. (Name Withheld - Confidential) Hospital, 2007 WL 901630 (Cal. Super., February 9, 2007).

Preeclampsia: Nurse Gave Pitocin, Ordered To Pay Share Of Verdict.

A complex case from the District Court, Bell County, Texas, resulted in a \$12,825,000 verdict for a child with cerebral palsy and other neurologic deficits related to oxygen deprivation at birth.

The physicians were accused of mismanaging the mother's preeclampsia and of ignoring non-reassuring fetal heart tracings during labor that should have called for an emergency c-section.

The labor and delivery nurse was held 25% responsible for the verdict because she continued giving pitocin in adherence to the physicians' plan to induce labor, in the face of non-reassuring monitor tracings which, pursuant to hospital pitocin policy, should have alerted her to stop. Dutton v. Scott & White Memorial Hosp., 2007 WL 866411 (Tex. Dist., February 28, 2007).

Prenatal Test: Fax To Doctor's Office Not Enough.

The record is sketchy in a labor and delivery case from the US District Court for the Eastern District of Louisiana. The court did stress the point that faxing the results of a non-stress test to the physician's office at 5:48 p.m. without ascertaining that the physician has been made aware of the test results does not fulfill a hospital's standard of care.

A prenatal test should be read by an experienced labor and delivery nurse and a decision should be made at the hospital whether or not an emergency exists. Jackson v. Slidell Memorial Hosp., 2007 WL 1030296 (E.D. La., March 27, 2007).

Pitocin: Nurses Broke Hospital Rules, Large Verdict For Patients.

The patient was admitted to the hospital as scheduled for childbirth.

She was two weeks past due, her water had broken and her labor had begun.

She and her husband at least twice expressly declined the hospital's nurse midwife's recommendation that pitocin be started, based on negative information about pitocin they were given in their natural childbirth class.

Pitocin Given Over Patient's Objections

The hospital's nurse midwife told the couple that their obstetrician had ordered pitocin and she was going to give it even though they had twice declined. At this point the mother was several hours into her labor with sixty- to ninety-second contractions at five- to seven-minute intervals.

Failure of Nursing Communication

There was an apparent breakdown in communication between the nurse midwife and the obstetric nurse. Each of them separately seemed to have carried out what they believed to be the physician's order to increase the pitocin hourly until adequate labor had been achieved.

Nurses Violated Hospital's Pitocin Rules

The hospital's own policies for administration of pitocin called for its discontinuance if contractions became more frequent than every two minutes or became tetanic. The pitocin was continued, however, and gradually increased, more than three hours after the mother's uterine contractions had become hyperstimulated.

The fetal heart rate became ominously slow and the baby was delivered by emergency c section.

The jury in the Circuit Court, Lee County, Florida, returned a verdict in excess of \$30 million for the family based on the severe cerebral palsy which the child now suffers. Edwards v. Lee Memorial Health System, 2007 WL 1096898 (Fla. Cir., February 28, 2007).

High-Risk Pregnancy: Death Of Newborn Tied, In Part, To Nursing Negligence.

The stillbirth of the baby was caused by multiple factors pointing to negligence by the patient's caregivers.

A high-risk Type I insulin-dependent maternity patient should be counseled toward induction or other means to accomplish delivery no later than the 39th week, and should not be allowed to go to the end of the 40th week like a normal pregnancy.

The couple phoned their facility to report the fetus did not seem to be moving and they wanted to come in for fetal monitoring.

Apparently failing to appreciate that it could be an emergency, the facility staff did not call back for more than five hours, that is, until a bed was available on the labor and delivery unit.

When the mother did arrive, fetal monitoring was started immediately. The first tracings were normal and reassuring.

When the tracings began to show late decelerations without variability, however, a c-section was done promptly, but the baby soon died.

MEDICAL MALPRACTICE ARBITRATION,
CALIFORNIA
January 25, 2007

The twenty-two year-old pregnant mother suffered from Type I insulin-dependent diabetes. Her baby died shortly after birth.

She delivered her baby at a hospital owned and operated by her health maintenance organization (HMO). Being members or beneficiaries of the HMO, the mother's, father's and baby's claims for malpractice could not be filed in court but had to be submitted to binding arbitration before an arbitrator appointed by an independent organization which furnishes arbitrators for civil cases.

The arbitrator awarded the couple \$400,000 for the death of the baby, based in part on the negligence of the HMO nursing staff who provided pre-natal care.

Nursing Negligence High-Risk Pregnancy

Three days before the mother actually went into the hospital she had an outpatient visit with a nurse on the facility's high-risk pregnancy team.

The nurse did a non-stress test that indicated the baby was healthy and examined her cervix for any sign that labor may have started.

The nurse reassured the mother everything was fine and told her to phone the hospital three days later, at the end of her 40th week, for instructions whether or not she was to come in to deliver her child.

According to two medical experts whose opinions the arbitrator relied upon in reaching his decision, labor should be induced for a high-risk maternity patient with Type I diabetes no later than the 39th week.

Therefore, according to the experts, the standard of care for a nurse or anyone else responsible for counseling a high-risk diabetic patient calls for the patient to be advised and prepared for the eventuality of having to come in for induction before the end of the 39th week. Alejandre v. Kaiser Foundation Hospitals, 2007 WL 816773 (Arbitration, California, January 27, 2007).

Patient Abuse: Nurse Used Pillow To Muffle Patient's Cries.

The eighty-two year-old hospital patient began to cry out in pain as his nurse tried to start an IV. When two more nurses came into the room to help with the IV, the patient began yelling for help.

Yet another nurse came into the room, grabbed a pillow and put the pillow over the patient's mouth to stop him from screaming. Her rationale was that other patients in adjacent rooms would be affected by the disturbing noises coming from the room. However, the nurse stopped trying to muffle the patient's cries when the other nurses insisted.

The Court of Appeals of Iowa ruled the one nurse's conduct fit the state criminal code definition of an assault and was, therefore, abusive. It was not necessary to wrestle with the definition of abuse in the state's patient-abuse statute. Wyatt v. Dept. of Human Services, 2007 WL 911892 (Iowa App., March 28, 2007).

Resident Unbuckles Chair Safety Belt, Falls: Facility Ruled Negligent.

The resident was eighty-two years old and resided in an extended care facility.

Earlier in the day she was agitated and confused and had been screaming and crying.

She was positioned close to the nurses station in her wheelchair with her seat safety belt fastened.

She unfastened her seat belt more than once. When she seemed to have calmed down the aide who was supposed to be watching her turned away to assist another resident.

The resident, now unsupervised, unfastened her seat belt again, stood up, fell and broke her hip. The jury found the facility negligent, but awarded no compensation. The District of Columbia Court of Appeals ruled that the jury awarding no compensation was "contrary to all reason" and ordered a new trial. Hogan v. Washington Nursing Facility, __ A. 2d __, 2007 WL 922250 (D.C., March 29, 2007).

Misconduct: Nurse Gave Unfamiliar Med Without Looking It Up, Termination For Cause Upheld.

A nurse new to the home health field was terminated after she admitted during a case-file review that she had given Soma to a client, a medication with which she was completely unfamiliar, without consulting a reference source for necessary information.

The state department of unemployment compensation denied her claim, ruling that she was fired for misconduct. The Court of Appeals of Ohio ruled in favor of her former employer and dismissed the nurse's civil lawsuit which had alleged wrongful termination and defamation of character.

**No Defamation Committed
Good Faith Basis Existed for File
Note Re Poor Nursing Practice**

The court supported her former supervisor's decision to place a notation

The home-health nurse was fired after admitting she gave a medication to a patient but did not know what it was, what it was intended for and what its possible side effects were, and did not look it up in a reference source.

The nurse's only excuse was that she had been working in pediatrics and was not familiar with adult medications.

COURT OF APPEALS OF OHIO
March 29, 2007

in her file that she had been terminated for poor nursing practice.

A former employee cannot sue a former employer for defamation over a derogatory statement in a personnel file if the statement was put in the file with a good-faith belief as to its truth.

Employers have a legitimate legal interest in communicating candidly regarding an employee's or former employee's job performance. As long as an unsatisfactory impression of an employee's competence is supported by proven factual evidence, the employer can communicate that impression to potential future employers. An employee must prove lack of good faith or actual malice to sue for defamation. Hatton v. Interim Healthcare, 2007 WL 902176 (Ohio App., March 27, 2007).