LEGAL EAGLE EYE NEWSLETTER

May 2008 *For the Nursing Profession* Volume 16 Number 5

Patient Hemorrhages, Dies Just Out Of The Hospital: Jury Blames The Discharge Nurse.

The patient was admitted to the hospital and had surgery to correct a misalignment of his jaw.

Hypertension Noted in PACU

In the post-anesthesia recovery unit the patient needed Apresoline, a short-acting anti-hypertensive used to treat hypertensive crises, in two doses two hours apart.

He received no further anti-hypertensive medication the next twenty-nine hours in the hospital's surgical intensive care unit before he was discharged.

History of Hypertension

The court record mentioned without elaboration that the patient had a history of hypertension before entering the hospital for this surgery.

Patient Hemorrhaged, Died Shortly After Leaving Hospital

The physician signed a discharge order shortly after 5:00 p.m. for the patient to leave at 5:30. The patient did not actually go until 6:30 p.m. because of a mix-up locating his keys and wallet.

Ten minutes after leaving the hospital, however, in the car on the way home, he began bleeding profusely from his mouth. His wife drove him back to an office building on the hospital campus and paramedics were called. They were unable to save him.

The surgical procedure was completed with no apparent complications.

The hospital discharge nurse breached the standard of care by failing to identify a potentially dangerous situation, a blood pressure of 179/88, failing to communicate to the physician and failing to re-take his blood pressure right before the patient actually left.

COURT OF APPEAL OF LOUISIANA
April 16, 2008

The autopsy established the cause of death as asphyxia from hemorrhage into his airway. The Court of Appeal of Louisiana pointed out the autopsy revealed no problem with how the surgery was done.

The jury returned a verdict for the widow and children for $1,834,914.31 based entirely on the negligence of the nurse involved in his discharge.

Nursing Negligence

The nurse took vital signs at 5:00 p.m. in anticipation of the patient's imminent discharge from the hospital.

The patient's blood pressure was 179/88, pulse 72 and respirations 16.

According to the court, the nurse did not communicate the blood pressure reading to the physician who was to sign the patient's discharge order.

Any abnormal finding at discharge like hypertension in a patient with acute and chronic histories has to be communicated.

The nurse also erred recording the 5:00 p.m. vital signs in a slot on the chart for 4:00 a.m. vitals, the court said.

The jury, in the court's judgment, had evidence to conclude the patient should have been kept in the hospital for observation and treated for his hypertension, and would have, but for the nurse's errors and omissions in the discharge process. **Lewis v. State, __ So. 2d __, 2008 WL 1777227 (La. App., April 16, 2008).**

Inside this month's issue ...

May 2008
New Subscriptions
See Page 3

Narcotics Diversion - Patient Suicide - Police Access To Patient
Fecal Incontinence - Hemostat Left Inside Patient After Surgery
Patient Falls - Faulty Transfer/Post-Hip Replacement
Whistleblower - Age/Disability Discrimination - Pressure Sores
Contractures - MI/Emergency Room - Labor & Delivery
Operating Room/O_2 /Spark/Fire - Nurse Midwives
Labor & Delivery/Nurse As Patient's Advocate - Patient Falls
MRSA/Occupational Disease/Workers Compensation

Narcotics Diversion: Nurse Sues Employer Over Confrontation, Court Dismisses The Lawsuit.

The prelude to the incident in question was a counseling session between the registered nurse and her supervisor over documentation errors with her narcotics.

The counseling session came after she checked out three 100 mg doses of fentanyl on one shift but documented only three 25 mg doses going to each of three patients and did not document proper wastage of the 3 x 75 mg total excess.

Soon afterward the nurse was called into a meeting with two nurse managers and someone from the hospital's employee assistance program. The nurse was told bluntly that she was suspected of narcotics diversion and on-the-job drug abuse. She was asked and agreed to give blood and urine samples. The three hospital representatives walked her down to the E.R.

The nurse was assured she was free to leave but was not allowed to drive her car parked on the street blocks away, based on suspicion she was presently under the influence. A female hospital police officer drove the nurse and her supervisor to the nurse's car to get some personal items, then back to the hospital. The nurse's boyfriend came and took her out to dinner. Then they went and got her car.

The drug tests came back negative. The nurse was fired anyway for substandard performance, that is, for medication documentation errors. She sued the hospital for false imprisonment over the way she was confronted. The Court of Appeals of Ohio threw out her lawsuit.

No False Imprisonment Occurred

The nurse voluntarily consented to be tested for drugs, albeit in the face of disciplinary action extremely prejudicial to her continued employment if she refused.

She was watched one-on-one but was never restrained from leaving the premises.

A private party can refuse to allow an apparently impaired individual access to a motor vehicle, that is, by threatening to notify law enforcement if the party tries to drive. **Sharp v. Cleveland Clinic, 2008 WL 1700527 (Ohio App., April 11, 2008).**

False imprisonment occurs when a private citizen intentionally confines another against his or her will.

A private citizen or corporate employer cannot detain another for drug testing, whether or not the private citizen or corporate employer has reasonable suspicion or probable cause.

A private citizen can threaten another with lawful consequences like disciplinary action but cannot bodily restrain another person against his or her will.

A private citizen can threaten to call the police if another person, believed to be impaired, tries to operate a motor vehicle, but, again, cannot physically prevent the person from accessing the vehicle.

Although the nurse in question was confronted by three persons and walked down to the emergency room for drug testing by three persons, they never restrained or threatened to restrain her physically.

She was at all times free to leave the hospital grounds and face the consequences of refusing to be tested for illicit drug use.

COURT OF APPEALS OF OHIO
April 11, 2008

Patient Suicide: Nurse Gave Patient A Razor, Did Not Check Back For Three Hours.

The forty-one year-old patient, a male attorney in solo legal practice, went to a neurologist for headaches and insomnia. Five days later he went to the hospital with complaints of increasing anxiety, difficulty concentrating and a sensation that his heart was racing out of control.

He was admitted to cardiac telemetry. His brain MRI came back normal. Finding no apparent organic pathology to account for the patient's symptoms the neurologist recommended the admitting physician order anti-anxiety medication and get a psychiatric consultation.

A telemetry unit nurse honored the patient's request for a razor to shave his chest hairs so the EKG leads would stop bothering him.

When the nurse checked on him three hours later he was dead by his own hand.

DISTRICT COURT, HIDALGO COUNTY
TEXAS
March 5, 2008

The patient's nurse noticed he was not in his bed. His bathroom door was locked so she called maintenance to unlock it.

They found the patient dead inside. He had slit his wrists and neck with the double-edged razor he had asked for to shave his chest hairs so that the EKG leads would stop bothering him.

The jury in the District Court, Hidalgo County, Texas awarded $9,000,000 damages from the hospital for his widow and three young children. **Villarreal v. Rio Grande Regional Hosp., 2008 WL 859667 (Dist. Ct. Hidalgo Co., Texas, March 5, 2008).**

Police Sought Access To Patient: US Appeals Court Rules Nurse's Actions Were Appropriate.

We first reported this story June 2007: *Police Wanted Access To Patient: Court Finds Nurse's Actions Were Appropriate,* Legal Eagle Eye Newsletter for the Nursing Profession (15)6, Jun. '07 p. 5.

The US Court of Appeals for the Seventh Circuit has affirmed the Federal District Court ruling that the nurse acted appropriately. That is, the nurse's civil-rights lawsuit is on solid ground against the deputy sheriff who arrested her at the hospital without legal justification.

Officers Tried to Serve a Protective Order In Hospital Med/Surg Unit

Around midnight two deputies came to the ICU to hand-deliver an emergency protective order to a sixty year-old male patient. They announced their purpose and asked to speak to the patient's nurse.

The nurse pointed out the patient's room. When the deputy inquired about the patient's condition the nurse said it would be best to call the doctor before the deputies went in to see the patient. The nurse was concerned the patient could stroke or experience other serious complications if confronted by a very stressful stimulus.

The deputy asked the nurse to call her supervisor. The nurse phoned the on-call physician who told her to tell the deputy the patient was not going anywhere and to come back in the morning when the physician would be at the hospital making her rounds. The physician also suggested the nurse call the nursing supervisor at home.

The deputy started getting agitated. He took away the phone while the nurse was speaking with her nursing supervisor and became even more agitated when the nursing supervisor likewise told him to come back at 8:00 a.m.

The nurse walked away to prepare an IV at the nurses station for another patient. The deputy went in and arrested her for obstructing service of process and obstructing a peace officer. She was taken out of the hospital in handcuffs.

Nurse Sued Deputy Her Constitutional Rights Were Violated

In the US an arrest requires a warrant or probable cause. There was no way, the courts ruled, the deputy could have thought the nurse's actions amounted to either of the offenses for which he arrested her. Thus there was no probable cause and her arrest violated her Constitutional rights.

The nurse told the deputy where the patient was located and did nothing to hinder him from contacting the patient. When the deputy asked she told him it was not advisable for him to have any contact with the patient and she got two responsible caregivers to back her up, still leaving the deputy free to do what he felt he had to do.

Shipman v. Hamilton, __ F. 3d __, 2008 WL 852144 (7th Cir., April 1, 2008).

Obstruction of a peace officer is a criminal offense. By definition it requires some sort of physical resistance intended to obstruct the officer in the execution of his or her lawful duties.

Obstruction of service of legal process is also a crime. "Service" means hand delivery of official legal papers. "Legal process" means court summonses, subpoenas, protective orders, etc.

This offense likewise requires some form of overt physical action meant to impede, hinder, interrupt, prevent or delay the process server in the performance of his or her lawful duty.

The nurse refused to give the officer permission to enter the patient's room, but permission was not hers to give or to withhold. She did not obstruct the officer.

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
April 1, 2008

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

© 2008 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

Clip and mail this form. If you prefer, order online at www.nursinglaw.com

Print $155/yr ____ Online Only $95/yr ____ 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
PO Box 4592
Seattle WA
98194-0592

Fecal Incontinence: Hospital Can Terminate Nurse For Medical Reasons.

The individual had a life-long battle with fecal incontinence stemming from congenital medical issues.

She worked as a hospital unit secretary, went to nursing school and was hired back by the same hospital as an RN.

Her condition caused problems with stained clothes, stained chairs and odors. She was told she had to wear incontinence pads and have changes of uniforms with her at work and to change immediately if she had an accident, but it did not work.

She was terminated shortly after a co-worker sat in a feces-stained chair.

A hospital has the right to maintain decorum and is not required to allow an unpleasant work environment to continue for co-workers.

However, this is not a disciplinary matter. The nurse has tried her best and is not at fault.

She will be terminated for failure to return from sick leave.

COURT OF APPEALS OF LOUISIANA
February 8, 2008

The Court of Appeals of Louisiana turned down the nurse's wrongful-termination lawsuit, agreeing with the state civil service commission's handling of the case not as a disciplinary matter but as a more-or-less permanent medical leave.

The nurse was certainly not at fault for her condition, but the hospital was not required to accept or to accommodate the problems it was causing on the unit. **Sibley v. LSU Health Science Center, 2008 WL 426273 (La. App., February 8, 2008).**

Hemostat Left Inside Patient's Body: Jury Faults Nurses, Not Surgeon.

The physician switched the patient's laparoscopic surgery to an open abdominal procedure when internal bleeding could not otherwise be controlled. The physician relied upon assurances from the perioperative nurses that all the counts were correct and then closed the incision.

The patient came back to the physician as an outpatient several times for intractable abdominal pain before it was discovered a hemostat had been left inside her abdomen. When the hemostat was removed it was discovered that it damaged her bowel.

The patient sued the physician but not the hospital. The jury in the District Court, Dallas County, Texas ruled the physician was not at fault and awarded no damages whatsoever, blaming it entirely on the hospital's perioperative nurses. **Hughes v. Boyd, 2008 WL 1733644 (Dist. Ct., Dallas Co., Texas, January 9, 2008).**

Fall Into Bathtub: Jury Blames Care Workers, Not Care Consultant.

A patient-care consultant under contract with a state agency to check on a developmentally disabled man's institutional care admitted that she, like his aide, left him sitting beside a bathtub full of hot water into which he fell and was scalded.

The jury in the Superior Court, Madison County, Indiana faulted the aide and the facility but ruled the consultant was only there to monitor his care and was not at fault. **McGhee v. Independent Care Management, Inc., 2008 WL 1734955 (Sup. Ct. Marion Co., Indiana, January 28, 2008).**

Faulty Transfer: Femoral Head Dislodged.

The patient went to a skilled nursing facility for rehab after hip surgery.

In a transfer from his bed to a chair by two facility employees his leg was bent and twisted underneath him, dislodging the femoral head of his hip prosthesis. The damage was discovered two days later when he was re-admitted to the hospital.

The facility was faulted for failing to provide staff adequately trained in transfer techniques who would appreciate his vulnerability to re-injury.

It was further alleged the facility's nursing staff was negligent for failing to detect that he had been injured in the transfer and for failing to appreciate the seriousness of the injury for two days while the patient was in obvious agony.

The facility succeeded only in winning a ruling from the Circuit Court, Winnegabo County, Illinois that punitive damages were not appropriate. **Ingarra v. Rosewood Care Center, 2007 WL 5075846 (Cir. Ct. Winnebago Co., Illinois, November 29, 2007).**

Duty To Supervise: Court Faults RN For Failing To Follow Up On LPN's Vitals.

The case was very complicated legally. The RN was a US Veterans Hospital employee and the LPN came from a private-sector nursing personnel agency.

The US District Court for the District of Colorado ruled that an RN supervising an LPN has to monitor the vital signs being obtained and has to follow up with an assessment when the temperature of a patient getting Tylenol for fever does not drop over a period of hours as expected. **Quintana v. US, 2008 WL 731115 (D. Colo., March 17, 2008).**

Job Change: No Age, Disability Discrimination.

For medical reasons a nurse asked to be transferred to a desk job from her job in the operating room which involved a substantial amount of time standing.

Her employer accommodated her request, but with a $5.95 per hour pay reduction based on the facility's standard pay rates for pre-admission testing nurse versus perioperative nurse.

The Superior Court of New Jersey, Appellate Division, ruled that the facility committed no age or disability discrimination.

The key in any discrimination case is to look for comparisons between the alleged victim and other employees in similar situations or as similar as can be found, the court pointed out.

A younger, non-disabled nurse had the same job title as the alleged victim but received the same pay as an O.R. nurse. However, she actually spent most of her time on her feet in the operating room.

A younger, less senior nurse with the same job title and the same, mostly sedentary duties, actually earned $5.00 per hour less than she, that is, $10.95 less than the nurse in question had earned in the O.R. **Robinson v. C.A.R.E.S. Surgicenter, 2008 WL 1744410 (N.J. App., April 17, 2008).**

Contractures: Facility Ruled Not Liable.

The jury in the Superior Court, San Diego County, California returned a defense verdict in a lawsuit filed against a nursing facility over in infected toe and bilateral knee contractures in an eighty-one year-old patient.

The nursing experts differed on the question whether the facility's nursing staff should have detected the infection in her toe soon enough that reporting it to the physician would have saved the toe from amputation.

The jury ruled the facility was not at fault for the contractures. The patient's daughter reportedly strongly believed in alternative medical cures. She was the patient's legal surrogate decision-maker and would not give consent for her elderly mother to get pain medication so that the physical therapists could work on range of motion for her knee contractures.

The facility nursing staff knew the contractures were a problem and asked the physical therapist to see the patient. However, they could not give pain medication and would not allow physical therapy without it. **Green v. Chase Care Center Inc., 2008 WL 747873 (Sup. Ct. San Diego Co., California, February 27, 2008).**

Whistleblower: Court Reviews Fired LPN's Lawsuit.

A recent opinion of the US District Court for the District of Minnesota reviewed the legal issues in a whistleblower lawsuit filed by an LPN who was terminated from her job in a nursing home.

The director of nursing asked the night-shift LPN to review specified patient charts to make sure there were complete care plans, anticipating a possible state survey inspection.

An employee working in healthcare cannot be terminated for refusing to perform an action which the employee has an objective reason to believe is a violation of state or Federal law.

UNITED STATES DISTRICT COURT
MINNESOTA
April 10, 2008

After she was terminated for alleged absenteeism, medication errors and not getting the care plans done as she was told, the LPN was informed by LPN co-workers at her next job that responsibility for care planning is a function reserved to registered nurses by state nursing regulations in Minnesota. If she was asked to perform an illegal act, writing care plans on her own as an LPN, and was terminated for refusing, she would have grounds for a so-called whistleblower lawsuit.

The problem was, however, she did not know at the time that what she had been asked to do was possibly a violation of the law. She never complained to her supervisors about her assignment on the basis that it would have been an illegal act.

The court said this could not be and was not a case of employer retaliation as contemplated by the whistleblower law. **Arends v. Extendicare Homes, 2008 WL 1734205 (D. Minn., April 10, 2008).**

Pressure Sores: Facility Liable.

The jury in the District Court, Jefferson County, Texas returned a verdict of $400,000 for a ninety-one year old Alzheimer's patient. The Stage II blisters she already had on each heel when admitted to the nursing facility progressed to Stage IV decubitus ulcers and required bilateral below-the-knee amputations.

There was reportedly no documentation in the nursing facility records about pressure relief for her heels or frequent turning in bed. **Limbrick v. Living Centers of Texas, 2008 WL 517564 (Dist. Ct. Jefferson Co., Texas, February 4, 2008).**

Post-MI Care: Cardiologist Ruled Not Liable.

The jury in the Circuit Court, Prince William County, Virginia ruled the cardiologist was not at fault for complications following an E.R. visit for chest pains.

The hospital's nurses reportedly waited ninety minutes to alert the cardiologist on duty that the patient's EKG showed bundle branch block and his labs showed elevated troponin levels. **Sobti v. Prince William Hosp., 2008 WL 942629 (Cir. Ct. Prince William Co., Virginia, January 16, 2008).**

Labor & Delivery: Court Places Independent Professional Responsibilities On Nurses

The US District Court for the District of Puerto Rico defined certain independent legal responsibilities that labor and delivery nurses owe to their patients irregardless of the orders, actions or inaction of the treating physicians.

The court did not try to compile an exhaustive list of nursing responsibilities beyond those relevant to the case at hand.

Pitocin

When Pitocin is in use the labor and delivery nurses have an independent legal duty to monitor the status of the fetus and must discontinue the Pitocin, or notify the physician to do so, if signs appear that the fetus is in distress, the court said.

Signs of fetal distress, for which the nurses should have stopped the Pitocin in this case were frequent contractions and a slow fetal heart rate.

Fetal Heart Monitor

According to the expert testimony endorsed by the court, when the external fetal heart monitor tracings become problematic it is a nursing responsibility to see that an internal monitor is started to obtain readings which will tell more reliably the true status of the fetus's condition.

Epidural Anesthetic

The patient needs to receive a bolus of IV fluid before an epidural is started, the court said, and the labor and delivery nurses are jointly responsible with the anesthesiologist for seeing it is done.

Once the epidural is going, the court went on to say, the labor and delivery nurses have the responsibility to watch the mother's and fetus's responses carefully. If the fetal heart rate drops the nurses must take the initiative and turn the mother on her left side and increase her IV fluids. The nurses have these responsibilities regardless of what the anesthesiologist is or is not doing for the patient, the court said.

Legal liability is imputed to the hospital for the nurses' errors and omissions. **Pages-Ramirez v. Hospital Espanol, __ F. Supp. 2d __, 2008 WL 1213051 (D. Puerto Rico, April 7, 2008).**

The law does not view nurses in the hospital setting as robots.

A hospital cannot escape legal liability by resting on the argument that the hospital's nurses were only following orders from a treating physician who was not a hospital employee.

While it does make sense that nurses must comply with physicians' commands in order for hospitals to run smoothly, the law nevertheless clearly requires nurses to meet certain independent standards of care.

The law requires nurses to use their own competency to avoid causing unnecessary harm to their patients.

If the physician will not heed the nurses' warnings the nurses must continue voicing their concerns up the nursing ladder of responsibility, an accepted healthcare industry guideline for nurses when they must question an order from a commanding physician.

In this case, however, the nurses blindly followed the doctor's instructions, causing the patient irreparable harm.

UNITED STATES DISTRICT COURT
PUERTO RICO
April 7, 2008

Fire In O.R.: Court Puts Burden Of Proof On Caregivers.

The patient was having surgery to remove tumors from his neck and ear. The anesthesiologist had him on blow-by O_2 from a tube by his nose which was separated from the surgical field on the side of his head by sterile surgical drapes.

A spark from the Bovie ignited the surgical drapes. The O_2 was turned off and the drapes were pulled away, but not before the patient was burned.

The anesthesiologist's insurance paid a settlement to get her out of the lawsuit. The Court of Appeals of Indiana ruled there still were legal grounds for the patient to sue the surgeon and the hospital.

The standard of care is not the issue. The patient can invoke res ipsa loquitur.

A fire in the operating room is something that does not happen in the ordinary course of events.

The doctors and the perioperative nurses were in control of all the equipment that caused the fire.

COURT OF APPEALS OF INDIANA
April 14, 2008

The court allowed the patient to invoke the legal rule of "Res ipsa loquitur," Latin for, "It speaks for itself."

Common-sense, the court said, tells us that a patient is not supposed to be burned by a fire in the operating room and it should not happen unless one or more caregivers have been negligent. The court relied on a prior case setting a legal precedent, involving an oxygen mask leaking on the side causing exactly the same outcome. The patient may, but is not required to have expert testimony on the standard of care. **Cleary v. Manning, __ N.E. 2d __, 2008 WL 1701176 (Ind. App., April 14, 2008).**

Delayed Cesarean: Nurse Midwives Found Negligent.

A medical malpractice arbitration in Orange County, California resulted in a settlement agreement for a life annuity with a present value of approximately $3,200,000.

A nurse midwife and student nurse midwife reportedly let the mother's labor go on for many hours in the face of late decelerations and other unspecified problems before they called in an obstetrician to perform a cesarean.

The child, now fourteen years old, suffers from cognitive and behavioral problems related to hypoxic birth injury. **Ehtemam v. Kaiser Permanente, 2008 WL 464886 (Med. Mal. Arbitration, Orange Co., California, January 10, 2008).**

Delayed Cesarean: Nurse Midwife Found Not Liable.

A jury in the Circuit Court, Fredericksburg, Virginia returned a defense verdict. The hospital which employed the certified nurse midwives was the only defendant, the plaintiffs having voluntarily dismissed the obstetrician.

The mother reportedly had a long and difficult labor. Her water broke at home at 2:30 a.m. and she went to the hospital at 8:30 a.m. where a certified nurse midwife was assigned.

It was not until 11:35 p.m. that the midwife called the obstetrician. The cesarean was completed at 12:15 a.m.

The basis for the jury's no-liability verdict was defense medical testimony interpreting the CT scan taken shortly after birth showing an intracranial bleed related to thrombi related to a placental infection which was not caused or affected in any way by the midwives' management of the labor. **Confidential v. Confidential, 2007 WL 4953373 (Cir. Ct. Fredericksburg, Virginia, August 15, 2007).**

Cesarean Delayed: $37,850,000 Verdict For Cerebral Palsy.

A jury in the Circuit Court, Hillsborough County, Florida apportioned fault 80% to the treating obstetrician and 20% to the hospital, the nurses' employer.

The hospital had already settled out of the case after the trial started but before the jury began deliberations.

Nursing and Medical Negligence Alleged

Nursing Negligence

The family's lawsuit alleged negligence by the hospital's nurses.

First, the labor and delivery nurse allegedly did not follow hospital rules for administration of Pitocin. The Pitocin was started, then increased after fifteen minutes. Five minutes later the mother's contractions became hypertonic. The nurse correctly stopped the Pitocin, gave O_2 and repositioned the mother. Ninety minutes later the nurse re-started the Pitocin.

Second, the nurses, in the opinion of the family's expert witness on nursing standards, failed to access the chain of command. Twenty minutes after re-starting the Pitocin the labor and delivery nurse observed late decelerations and found the mother had a 101° fever.

The obstetrician did not want to do anything, so the labor and delivery nurse, acting correctly, went to her supervisor.

The nursing supervisor, however, did not speak with the obstetrician right away herself or ask a more senior nursing officer to step in. Two and one-half hours later, becoming more and more concerned with the monitor strips, the nursing supervisor did speak with the obstetrician. The supervisor told the labor and delivery nurse to continue having the mother push, then went behind the obstetrician's back to alert a c-section team to stand by.

Medical Negligence

The family's obstetric experts testified that the cesarean should have been done three to four hours earlier than it was done.

The labor and delivery nurse notified the patient's obstetrician at 7:00 p.m. there was a problem with late decelerations.

The nursing supervisor again took up the issue of the monitor strips at 9:20 p.m. The obstetrician left the room for one and one-half hours with instructions simply to have the mother keep pushing.

The obstetrician finally called for the c-section at 10:40 p.m., and left the room again for another hour.

The c-section did not actual begin until 11:41 p.m., and the infant was delivered seven minutes later. **Coleman v. Martinez, 2007 WL 5022487 (Cir. Ct. Hillsborough Co., Florida, November 19, 2007).**

Cesarean Delayed: $38,500,000 Verdict For Cerebral Palsy.

A jury in the Superior Court, Stamford-Norwalk, Connecticut found the obstetrician 100% at fault and dismissed the hospital from the case.

One twin was delivered unharmed vaginally with forceps.

Trouble began immediately when the obstetrician ruptured the membranes for the second twin. The heart rate dropped and it appeared there was a prolapsed cord. The obstetrician worked for ten minutes trying to deliver the second twin vaginally, then called for an emergency c-section. According to the patient's experts, the obstetrician took a "meticulous" rather than expeditious approach to the procedure, resulting in a total period of twenty-five minutes of bradycardia and hypoxia.

The nurses were reportedly accused of failing to advocate for a cesarean through the chain of command, but the jury rejected that accusation. **Oram v. de Cholnoky, 2008 WL 793692 (Sup. Ct. Stamford-Norwalk, Connecticut, February 8, 2008).**

MRSA: Court Says Infection Is Covered By Worker's Comp As An Occupational Illness.

Two or three weeks after the aide began working at the state hospital she started to notice large boils on her arms. Her own physician cultured the lesions and confirmed it was methicillin-resistant Staph aureus (MRSA).

The state worker's compensation commission ruled that the aide's infection was covered under worker's compensation. The hospital appealed the commission's decision, but the Court of Appeals of Virginia ruled in the aide's favor.

Occupational Disease Defined

The worker must present medical evidence that the occupational disease arose out of an in the course of the worker's employment and did not result from causes outside of employment. An infectious or contagious disease must be shown to be characteristic of or caused by conditions peculiar to the worker's specific job.

Proof Of Contact Was Lacking

The aide was asked to identify which of the twenty or so mental-health patients she frequently cared for she believed had given her MRSA. All of them tested negative.

However, the aide's lawyer got testimony from an infectious disease specialist that MRSA is much more prevalent in hospital settings than in the community at large, and in hospital settings most prevalent in long-term institutional populations like mental-health patients who tend as a rule to have poor personal hygiene. CDC data support this connection.

No Prior Incidence of MRSA

The aide had worked in hospital settings before and had never had the furuncles characteristic of Staph infection, with an established four– to ten-day incubation period, that she got right away when she started to work at the state hospital. In her previous employment settings, working as an E.R. clerk and x-ray tech, patients were routinely screened for MRSA and none was ever found to be positive.

At the state hospital, unlike her previous employments, there was lots of direct bodily contact when patients grabbed and held her, a characteristic mode of Staph transmission. **Central State Hosp. v. Beckner, 2008 WL 762190 (Va. App., March 25, 2008).**

Patient Falls: Jury Finds Nursing Assessment, Care Negligent, Awards Family $1,000,000 Verdict.

The eighty-four year-old patient was in the hospital recovering from cardiac surgery after a heart attack.

For several days she was heavily medicated and remained basically unconscious.

Four or five days after surgery she was beginning to regain consciousness and started using a bedside commode with hands-on help from two nurses.

The patient remained heavily medicated. That made her highly disoriented. While disoriented she tried several times to get out of bed by herself. The first few times nursing staff members were able to intervene and put her safely back to bed.

Then, during the night six days after surgery, she got up, fell, injured her head and elbow and broke her hip.

The patient's fall-risk should have been reevaluated at least every twenty-four hours after surgery.

The family expressly asked if they could stay with her the night following the day she was caught several times trying to get up but was safely put back to bed.

The nursing staff refused to allow the family to remain in the room.

SUPERIOR COURT, MARION COUNTY
INDIANA
February 4, 2008

She died more than two years later from atherosclerosis unrelated to the fall. The family then filed suit for the injuries from her fall. The jury awarded them $1,000,000.

The family's nursing expert testified that the patient's repeated attempts to get out of bed mandated ongoing re-evaluation of her fall risk.

Even though the nursing staff were able to intervene, there was no guarantee that expecting to catch her in the act of getting up would continue to be an effective strategy. A bed alarm was not enough. All four bed rails should have been raised and the patient evaluated for restraints. The family should have been allowed to stay with her at night. **Estate of Gehrich v. St. Francis Hosp., 2008 WL 1051810 (Sup. Ct. Marion Co., Indiana, February 4, 2008).**