LEGAL EAGLE EYE NEWSLETTER

May 2009 *For the Nursing Profession* Volume 17 Number 5

Patient's Fall: Solid Nursing Documentation Afterward, Negligence Lawsuit Dismissed.

The patient was admitted to the facility's Alzheimer's unit after he began having behavior problems at home associated with sleeplessness, confusion and disorientation during the late-night hours.

His medical history included a transurethral resection for benign prostatic hypertrophy.

The patient's roommate was moved into the Alzheimer's unit after he began urinating on the floor and on other residents' beds and was seen as a safety risk to other residents of the facility.

He took medication for bladder control and wore diapers at night.

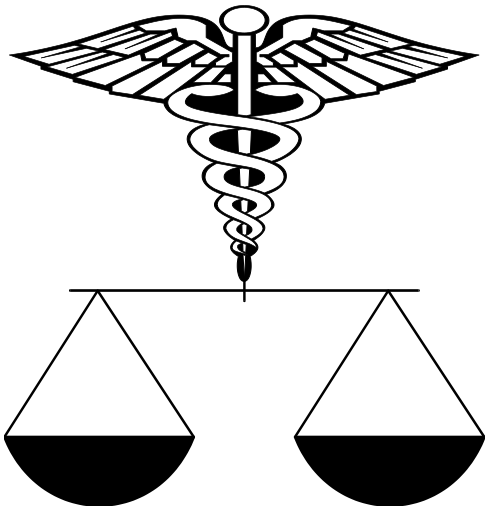
Patient Was Found on the Floor
Nurse Noted What She Saw,
What Patient Said, What She Did

The nurse found the patient on the floor. He said he got out of bed to go to the bathroom and fell in a puddle of urine that was not his own.

The nurse charted what she actually observed, that the patient was on the floor and there was a puddle of liquid, and what the patient said.

The nurse's progress note went on to document the nurse's assessment of the injuries and how the nurse got medical attention for the patient.

The patient had a broken hip. He died in the hospital right after having surgery for the hip.



The nurse charted how she found the patient, what she saw, what the patient said and what she did.

The nurse did not speculate what the liquid was or how it got on the floor.

Maybe the patient himself voided right before or right after he fell. That was just as plausible as the roommate having urinated on the floor.

COURT OF APPEAL OF LOUISIANA
March 27, 2009

Family's Lawsuit Alleged Negligence
Negligence Not Proven

There was no way to hide the facts. There was liquid on the floor. The patient fell and was seriously injured.

How, why and whose fault it was was an entirely different matter.

The patient said it was someone else's urine on the floor. With his cognitive deficits the patient's statements would never stand up in court. With his own urinary problems it was just as plausible that he himself voided on the floor right before or right after he fell.

How the nurse phrased her progress note was key. The nurse noted the obvious facts but never speculated where the liquid came from, whether it was urine or what caused the patient to fall.

The facility's DON testified about his own investigation. The nurse told him she found the patient on the floor, she saw liquid on the floor which the patient said was someone else's urine and she assessed and helped the injured patient.

The DON likewise never tried to speculate exactly how or why the incident occurred.

The Court of Appeal of Louisiana ruled the family's wrongful-death lawsuit failed to prove that the incident was caused by the negligence of any facility employee. **Shaw v. Plantation Management, 2009 WL 838680 (La. App., March 27, 2009).**

http://www.nursinglaw.com/may09bob6.pdf

May 2009

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Post-Surgical Infection: Court Faults Discharge Instructions.

The seventy-five year-old patient sustained a tibial plateau fracture in a fall at home.

Surgical repair at the hospital involved implanting an external fixation device with orthopedic pin hardware protruding from the skin.

The patient was transferred from the hospital to a skilled nursing facility. Ten days later, back to the hospital for a scheduled follow-up appointment, acute osteomyelitis was found to have set in, requiring a lengthy re-admission to the hospital, two surgical debridements, amputation and yet another debridement.

Teaching / Discharge Instructions Must Be Adequate to Protect Patient From Inadequate Post-Op Care

The judge in the US District Court for the Southern District of Illinois stated for the record the orthopedic surgery was done expertly.

There was also nothing wrong with the pin-site care provided in the hospital by the nurses and P.A.'s.

Different personnel had their own methods, involving sterile gauze pads or Q-tips, soapy water, sterile saline or peroxide. There are many acceptable ways to clean surgical pin sites, the court said, but that was not the point.

The point in this case was the patient himself was never taught or given discharge instruction on proper pin-site care.

Staff at the skilled nursing facility where he was going for rehab, not the patient himself, were going to provide the actual hands-on care.

Nevertheless, according to the court, the patient himself needed to be taught the basics of what needed to be done and how important it was to his wellbeing.

The patient himself needed to be made aware so he could assess whether the licensed and non-licensed staff at the rehab facility were doing their jobs right managing his orthopedic hardware.

He also had to be taught what to do if his needs were not being met, that is, to get back in touch with the hospital so that proper post-op care could be resumed, the court said. **Grizzell v. US, 2009 WL 792597 (S.D. Ill., March 24, 2009).**

The legal standard of care for pin-site care after orthopedic surgery is not the issue in this case.

Any caregiver would agree that a surgical wound, particularly an orthopedic pin site, must be kept clean to prevent infection. Basic cleanliness is the goal and there are many acceptable methods to accomplish it.

The real legal issue in this case is the patient teaching that should have been given to the patient.

Was the patient teaching adequate for the patient to protect himself if his post-discharge care proved to be inadequate?

Even if he is going to skilled nursing and is not going to do it himself, the patient must be taught how the pin sites must be cleaned daily to prevent infection, the signs of infection to watch for and what to do for an infection.

This patient was medicated on Vicodin for the ride to the skilled nursing facility and the discharge papers were handed to the attendant who was going to transport him.

Ten days later he came back to the hospital with a raging post-op infection.

UNITED STATES DISTRICT COURT
ILLINOIS
March 24, 2009

Patient Falls: Restraint Was Removed, Hospital Found Liable.

The seventy-four year-old patient was placed in a waist restraint in bed while recovering from an allergic reaction to morphine which reportedly left her confused and disoriented.

She was later found on the floor in her room with a broken hip. Her waist restraint had somehow been removed.

The patient was hospitalized almost eighteen months after hip surgery before she died. The jury in the Court of Common Pleas, Hamilton County, Ohio returned a verdict of $127,188.10 for the family.

An agency nurse who was not a hospital employee was assigned to care for the patient at the time she fell. The jury found no evidence that he was the one who negligently removed the restraint. The agency nurse and his agency were dismissed as defendants, leaving the hospital itself as the only defendant liable for the verdict. **Heidecker v. Mercy Hosp., 2008 WL 5744049 (Ct. Com. Pl. Hamilton Co., Ohio, September 5, 2008).**

Fall: No Assist To Bathroom.

The patient's wife went to the nurse's station to get someone to help her husband to the bathroom.

The nurse reportedly told her she was too busy.

The patient, one week post surgery for heart valve repair, got up on his own, went to the restroom and then fell and broke his hip while trying to get back into bed when the bed moved because the wheels were not locked.

The case filed in the Circuit Court, Wayne County, Michigan settled for $125,000. **Haddad v. Zdzinnicki, 2008 WL 5786789 (Cir. Ct. Wayne Co., Michigan, April 25, 2008).**

Hospital Discharge: Psych Patient Not Sent To Appropriate Care Setting, Nurse Liable For Death.

The fifty-three year-old schizophrenic patient had spent most of his adult life in psychiatric institutions and group homes.

His last residence before he died was a nursing home. The nursing home had an attendant take him to the outpatient urology clinic on a New York City hospital campus for evaluation of a urinary tract infection. The urologist did an outpatient bladder scan.

The urologist decided rather than go ahead with cystoscopy in the outpatient clinic it was better to admit the patient to the hospital so that cystoscopy could be done in the operating room.

The urologist reportedly told the attendant not to wait around for the patient as he would not be done until very late that evening. In fact, the patient would not be discharged until the next morning.

Nurse's Discharge Instructions Told Patient He Was "Going Home"

After the cystoscopy the patient got a Foley catheter and a urine bag. The discharge nurse's patient teaching apparently focused on how to take care of the catheter and empty the urine bag.

After going through the basics of Foley care the nurse simply allowed the patient to walk out of the facility alone.

The discharge nurse, regardless of what other hospital staff did or did not tell her, should have realized the patient was mentally ill and not able to meet his own basic needs in the community.

There were repeated references in the chart to the fact the patient was mentally ill and lived in long-term care. The nurse should have seen to it that he was returned to the nursing facility he came from to the hospital.

The jury ruled that the treating physician did depart from good medical practice. He failed to note expressly in the chart that the patient was to be sent back to the nursing facility where he resided.

However, the physician's omission was not what caused the patient's death.

NEW YORK SUPREME COURT
NEW YORK COUNTY, NEW YORK
January 30, 2009

The patient was found dead in a New York City park eleven days later. The autopsy revealed he had gone without food or water for several days before he died and he apparently pulled the Foley catheter out by himself.

The family's lawsuit pointed to a breakdown in communication between the urologist, the urologist's physician's assistant and the discharge nurse.

It was not clear if the physician's assistant and the discharge nurse ever spoke directly. The discharge nurse nevertheless was somehow given to understand that the patient was to be discharged "home."

Not having reviewed the chart carefully the discharge nurse failed to realize that "home" for this patient meant the nursing facility he came from, not an independent discharge into the community.

The hospital's policy was that any patient with special discharge requirements was to be referred by the treating physician to the hospital social worker prior to discharge.

In this case the social worker, the nurse or someone else could have simply made a phone call to the nursing home to send someone to come and pick him up.

The nurse settled before jury deliberations for $625,000 and the hospital settled for $125,000. The jury in the New York Supreme Court, New York County then returned a verdict clearing the urologist from liability. **Henderson v. North General Hosp., 2009 WL 903559 (New York Supreme Court, New York Co., New York, January 30, 2009).**

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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

Age Discrimination: Appeals Court Upholds Nurse's Verdict.

The US Court of Appeals for the Third Circuit upheld the jury's verdict in the nurse's favor in her age discrimination case we reported in March, 2008. See *Post-Mortem Care: Nurse Fired Over Handling Of Miscarriage Wins Discrimination Lawsuit,* (16)3, p.5.

The sixty-one year-old labor and delivery nurse had worked at the hospital nearly forty years, twenty-two years as an RN, with an unblemished employment record.

A patient of hers had a miscarriage while on the toilet. Following instructions from the physician the nurse had the OB tech put the eighteen-week fetus, placenta and cord into a container of formalin.

No Policy In Effect At the Time For Handling of Miscarriage

At the time there was no policy in effect at the hospital for handling the products of conception after a miscarriage. Later the hospital enacted a policy that it is inappropriate to put a miscarried fetus in formalin under twenty-four weeks.

Nurse Was Abruptly Terminated Four Days Later

The OB tech went to the unit manager to complain about being told to put the remains in formalin. After talking to the physicians, but without speaking with the nurse or the patient or reviewing the patient's chart, the unit director and clinical director decided to fire her.

The grounds they gave for termination were failure to adhere to expected standards of practice and behavior inconsistent with customer service expectations.

Stated Reasons For Termination Were Pretext for Age Discrimination

It came to light during the trial that the hospital had no policy until after this incident instructing a nurse what to do in this situation. The physicians testified the nurse's actions were not inappropriate.

Her supervisors reportedly were not even able to articulate a consistent story why they fired her, let alone grounds that would justify what they did.

The jury awarded $273,366.92 to the nurse for her loss of income from wrongful termination. **Scanlon v. Jeanes Hosp., 2009 WL 840553 (3rd Cir., April 1, 2009).**

A sixty-one year-old nurse was abruptly fired and her day shift position was given to a newly-hired thirty year-old nurse who wanted to work days.

That alone is enough to create a prima facie case of age discrimination in favor of the fired nurse.

When an employer treats a person in the protected 40-70 year old age bracket adversely compared to a younger person, the employer has the burden of proof.

The employer is required to prove that some factor other than age bias was the motivation.

The nurse could not have violated hospital policy.

There was no policy until after this incident how a labor and delivery nurse was to deal with the products of conception after a patient suffered a miscarriage.

The nurse's supervisors also testified the nurse had been bickering with a co-worker, but they left it up in the air how that would justify firing a long-term employee with an fine record and why the much-younger co-worker was not also fired for bickering with her.

The nurse is entitled to the jury's verdict.

UNITED STATES COURT OF APPEALS
THIRD CIRCUIT
April 1, 2009

Race Discrimination: Nurses Violated Hospital Policy, Terminations Upheld.

Two African-American nurses, an RN and an LVN, filed suit against the same hospital for race discrimination.

The hospital reportedly was able to prove in court that each termination was based on a violation of hospital medication administration policy and the state's Nurse Practices Act, that is, each of the nurses administered a medication to one of their patients without first obtaining a physician's order.

The jury in the US District Court for the Western District of Texas ruled that race was not a factor in either of the terminations and the cases were dismissed. **Gilyard v. Texas Laurel Ridge Hosp., 2009 WL 754896 (W.D. Tex., March 4, 2009).**

Rudeness: Nurse Disciplined.

An emergency room nurse was written up and given a three-day suspension for "rudeness" toward an EMT who asked the nurse to check on a patient he had just brought in.

Although the hospital never expressly defined "rudeness" in a code of conduct for its nurses, the Court of Appeal of Louisiana ruled that a healthcare facility can expect nurses to treat other professionals with respect and dignity and to refrain from demeaning and condescending remarks.

Courteous interaction and cooperation among treatment professionals are in the best interests of the hospital's patients, the court believed. **Farrar v. Louisiana State Univ., 2009 WL 839047 (La. App., March 27, 2009).**

Elder Abuse: Court Protects Supervisor For Discipline Of Nurses Aides.

A charge nurse in a nursing home was fired for an incident in which she allegedly became loud and argumentative with the CNA's over the way they were making up the patients' beds.

The charge nurse had a specific way she wanted the chux pads positioned to direct wetness away from patients' skin.

Common-Law Employee at Will Rule Must Bend for Public Policy Against Elder Abuse

The Court of Appeals of Iowa noted that the charge nurse did not have an employment contract and was not working under a collective bargaining agreement.

A common-law employee at will, as a general rule, can be let go by the employer at any time for any reason.

However, the employee-at-will rule does not justify disciplinary action by an employer that goes against public policy.

An employee cannot be fired for a reason that violates public policy.

COURT OF APPEALS OF IOWA
March 26, 2009

The court upheld the basic premises behind the fired charge nurse's wrongful-discharge lawsuit against her former employer.

The charge nurse was in the act of trying to prevent elder abuse when she got into the verbal altercation with the CNA's that resulted in her firing; prevention of elder abuse is a public policy that deserves validation by the courts.

Although her legal status at the time was only an employee at will who has few, if any rights, the charge nurse has grounds to sue her former employer over her firing, the court ruled. **Tuttle v. Keystone Nursing Ctr., 2009 WL 779538 (Iowa App., March 26, 2009).**

Medical Confidentiality: HIPAA Applies To Employees' Charts.

The nursing supervisor violated the nurse's medical confidentiality when she looked in the nurse's E.R. chart to see if the physician had excused her from work.

The US Health Insurance Portability and Accountability Act (HIPAA) protects the medical confidentiality of employees who are also patients where they work.

Violation of medical confidentiality usually would be sufficient justification to terminate an employee of a healthcare facility.

However, the way the hospital applied its policy for medical confidentiality has implications going beyond the rules protecting patient confidentiality.

When the facility terminated this nursing supervisor, an African American, the facility committed race discrimination. A Caucasian nursing supervisor who had done the same thing in the past was never disciplined.

When a facility imposes an outwardly appropriate disciplinary policy on a minority employee but not a non-minority, the minority employee, even if guilty of serious misconduct, has grounds to claim race discrimination.

UNITED STATES DISTRICT COURT
ARKANSAS
April 1, 2009

A hospital staff nurse called in sick on Monday for Monday and Tuesday. Hospital policy was that nurses were not supposed to call in sick more than one day in advance.

The nurse's phone call indicated she was seen in the hospital's own emergency room for her present illness. The nurse's unit supervisor got the nurse's chart from the E.R. and checked to see if the physician had excused her from work both Monday and Tuesday as she claimed. Then the supervisor called human resources to discuss what to do about an unexcused absence from work.

The human resources manager shot back with a memo to the effect that the nursing supervisor had violated the staff nurse's right to medical confidentiality in violation of hospital policy and Federal law.

The nursing supervisor was promptly terminated.

Minority Disciplined More Harshly Than Non-Minority Court Finds Race Discrimination

The US District Court for the Eastern District of Arkansas pointed out that violation of any patient's right to medical confidentiality can be grounds for termination, whether or not the patient also happens to be an employee of the facility. However, in this case there was more to it than that.

The terminated nursing supervisor in this case was African-American.

A Caucasian nursing director who in the past had openly admitted in a staff meeting that she had looked at an employee/patient's chart without permission never faced any disciplinary action.

It is blatant race discrimination to take harsher disciplinary action toward a minority than a non-minority employee for the same offense, the court pointed out.

Anti-discrimination law requires the same disciplinary action to be handed out for the same offense to every employee regardless of race.

Whether the harshness of the punishment matches the seriousness of the offense is only one facet of the question. **Scott v. Helena Reg. Med. Ctr., 2009 WL 903450 (E.D. Ark., April 1, 2009).**

EMTALA: Dehydrated Pediatric Patient Dies, Nurse Neglected E.R. Screening Procedure.

The six year-old patient was sent home with his parents from the emergency department 9:30 p.m.

Early the next morning his mother could not wake him and called paramedics to the home. They brought the child to the hospital at 6:46 a.m. Resuscitative efforts were stopped at 7:04 a.m.

The cause of death was established later that morning after his stool sample came back from the lab: dehydration from vomiting and diarrhea from *C. difficile*.

Emergency Room Nurse Did Not Take Initial or Follow-Up Blood Pressures

The parents sued the hospital in the US District Court for the Northern District of Indiana for violation of the US Emergency Medical Treatment and Active Labor Act (EMTALA).

Established policies were in place at the hospital for uniform appropriate medical screening of emergency patients. Among other things, the nurse was required to obtain a blood pressure when the patient first came in and to obtain repeat blood pressures every two hours until the patient left, if the patient was at least six years old.

The nurse never took this patient's blood pressure. Neither did the two physicians who examined the child, but the court gave them the benefit of the doubt. They could assume the nurse was monitoring the blood pressure and would have told them if it was outside the normal range.

The hospital did not follow its own medical screening procedures. The nurse not obtaining blood pressures, which likely would have been abnormally low, was a violation of the hospital's legal obligations under the EMTALA.

That EMTALA violation, the court went on to say, probably concealed a key physiologic sign of dehydration from the personnel who were treating a pediatric patient who was vomiting and having diarrhea and required fluid replacement and continued observation. **Bode v. Parkview Health, 2009 WL 790199 (N.D. Ind., March 23, 2009).**

An appropriate medical screening examination within the capability of the hospital's emergency department is a basic requirement of the US Emergency Medical Treatment and Active Labor Act (EMTALA) for any individual who comes to the emergency department for examination or treatment.

The EMTALA does not define the nuts and bolts of an appropriate medical screening examination. The focus, instead, is on equality and uniformity in the way emergency patients are handled.

The original intent of the Act was to prevent so-called "patient dumping" of the poor and uninsured. However, the courts now say that rich and poor, insured and uninsured alike can sue under the EMTALA.

Under the EMTALA the court looks to see if the hospital had an established screening procedure for the patient's constellation of signs and symptoms and whether the hospital applied that procedure to this patient the same way as any other emergency patient with similar signs and symptoms.

UNITED STATES DISTRICT COURT
INDIANA
March 23, 2009

EMTALA: Nurse Screened OB Patient, Hospital Not Liable.

At 7:00 p.m. a young pregnant woman arrived in emergency room. She was brought in her family because she was having severe abdominal pain.

A nurse saw her at 7:10 p.m. before she registered at the desk. Her main complaint was abdominal pain, ten on a scale of one to ten. Her history included a UTI diagnosed by her ob/gyn two days before.

The nurse took vital signs, i.e., BP, pulse, respiratory rate, O_2 sat and temp, all within normal ranges.

The nurse's triage categorization was urgent but not emergent. Then the nurse sent the patient to the registration desk to sign in.

Patient Waited Ninety Minutes Miscarried in Bathroom

Ninety minutes later the patient miscarried her sixteen-week fetus in the bathroom. Two women went and got a nurse who came and wrapped the fetus in a towel and escorted her back to the waiting area.

A physician saw her about fifteen minutes later, did a pelvic exam, ordered lab tests and talked to an ob/gyn on the phone. They discharged her home in stable condition at 11:00 p.m. with pain medication.

No EMTALA Violation Lawsuit Dismissed

The US District Court for the Northern District of Illinois ruled the hospital did not violate the US Emergency Medical Treatment and Active Labor Act (EMTALA).

The patient was promptly seen by a nurse, assessed, examined and appropriately triaged within minutes after arriving, even before being asked to register.

There was no evidence the hospital deviated in this case from its standard screening procedures.

While the patient was waiting, the court noted in passing, the E.R. staff had other matters to deal with, a patient in cardiopulmonary arrest, a patient who was seizing and another patient suffering from acute chest pains. **Barrios v. Sherman Hosp., 2009 WL 935750 (N.D. Ill., April 3, 2009).**

Arbitration: Daughter Had No Authority To Sign, Case Will Go To Jury.

In an effort to reduce litigation costs and to control runaway jury verdicts in medical negligence cases, hospitals, nursing centers and many other healthcare facilities are offering their patients the option of so-called alternative dispute resolution.

Alternative Dispute Resolution Requires Valid Arbitration Agreement

Arbitration of a civil dispute is appropriate as an alternative to trial by jury only when both sides have knowingly and voluntarily agreed to arbitration. In healthcare settings that means that the patient or the patient's authorized representative already signed an arbitration agreement at the time of admission, before the dispute over the quality of care came up.

In a recent case, the adult daughter was asked to sign the arbitration agreement when the elderly patient was being admitted to long-term care for Alzheimer's and other debilitating medical conditions.

The daughter said she was willing to agree to arbitration, but she protested that her mother was the person named in her father's power of attorney. The facility's admissions counselor told her it was all right for her to sign anyway and she did.

After the patient passed away in the facility his widow, acting as personal representative of his probate estate, sued the facility for negligence.

The Court of Appeals of Kentucky had to decide only the preliminary issue whether the case belongs in arbitration.

The strength of the underlying allegations of negligence remains to be determined.

The court threw out the arbitration agreement. Facility staff obtained a signature they should have known was a legally invalid signature on the arbitration agreement from a person they knew had no legal authority to sign for the incapacitated patient. **Beverly Health and Rehab v. Smith, __ S.W. 3d __, 2009 WL 961056 (Ky. App., April 10, 2009).**

Prenatal Care: Student Nurse Misread Fetal Monitor.

The mother went to the hospital after she awoke with nausea and started vomiting. She was also having mild labor contractions.

A student nurse put the patient on a fetal monitor, saw nothing in the monitor tracings to indicate a problem with the mother's pregnancy and sent her home with a sleeping medication.

Two days later the mother awoke in labor. She went to the hospital again and this time had an emergency cesarean. The baby suffered significant oxygen deprivation at birth. The child died from cerebral palsy at four years of age.

A student nurse at the hospital apparently looked at the monitor tracing as a contraction stress test.

During a contraction stress test, no change in the fetal heart rate is considered normal and reassuring.

The student nurse did not look for or did not understand the ominous significance of late decelerations of the fetal heart rate.

COURT OF COMMON PLEAS
YORK COUNTY, SOUTH CAROLINA
February 13, 2009

The jury in the Court of Common Pleas, York County, South Carolina awarded the parents $4,405,000 from the hospital for the student nurse's negligence.

The same ob/gyn who delivered the baby saw the mother when she came in two days earlier. The judge ruled the ob/gyn was not negligent and blamed only the student nurse for not reporting accurately to him. **Wilson v. Piedmont Med Ctr., 2009 WL 754849 (Ct. Com. Pl. York Co., South Carolina, February 13, 2009).**

Disabled Adult: Supervision Faulted, Jury Awards Large Verdict.

A thirty-six year-old brain-injury victim lived at home for ten years following his motor vehicle accident before his wife admitted him to an assisted-living facility.

His wife reportedly informed facility staff responsible for his care plan that he had a history of ingesting non-food items. He once put five packages of crackers in his mouth and swallowed them whole with the wrappers still on.

At the facility he reportedly swallowed large pieces of plastic sheets, paper towels, unopened ketchup packets and a candy wrapper. He vomited twice but no physician was notified and he died that evening. The coroner ruled the death accidental, but a jury in the Superior Court, Maricopa County, Arizona awarded $11,000,000 based failure to train staff and negligent supervision. **Scherrer v. Liberty Manor, 2009 WL 94397 (Sup. Ct. Maricopa Co., Arizona, March 19, 2009).**

Labetalol: Nurse Not Negligent.

The E.R. physician ordered labetalol for the patient, thirty-eight weeks pregnant. The drug was given IV by a nurse.

The patient's BP crashed, she arrested and died. Her ob/gyn was able to save the baby with an emergency c-section.

The jury in the Superior Court, Essex County, Massachusetts faulted the E.R. physician but not the nurse. Labetalol is contraindicated with congestive heart failure, but it was the physician's responsibility to consult with the ob/gyn who was more familiar with the patient and/or a cardiologist for an accurate diagnosis before ordering the drug. **Jardine v. Knee, 2009 WL 903939 (Sup. Ct. Essex Co., Massachusetts, January 22, 2009).**

legal eagle eye newsletter
For the Nursing Profession

Strip Search: Nurse Violated Students' Civil Rights.

The school superintendent was investigating a series of thefts at the school.

He brought in two suspects, then aged thirteen and fifteen, to the school nurse's office for strip searches. The school nurse had the girls remove their shirts and loosen their bras. The nurse found no evidence and she let the girls go.

The former students, now young adults, sued the school district, the superintendent and the school nurse in the Superior Court, Hunterton County, New Jersey.

Their lawyers were prepared to argue that a school nurse is not a police officer and has no actual law-enforcement authority. At the same time a school nurse can violate students' civil rights by acting under the guise of apparent legal authority from the State.

There was no proof of emotional trauma or psychological damage to either of the former students who each got a $75,000 pre-trial settlement. **"N.S." v. Stuby, 2009 WL 839168 (Sup. Ct. Hunterton Co., New Jersey, January 22, 2009).**

Sexual Harassment: Nurse Obtains Large Jury Verdict.

A jury in the Supreme Court, Queens County, New York, recently awarded a nurse $15,000,000 for sexual harassment by a former hospital staff physician, 50% to be paid by the physician and 50% to be paid by the hospital.

Shortly after she started working at the hospital the physician began flirting with her and suggesting they date. When he cornered her and fondled her she filed a written complaint, which promptly led to the physician's staff privileges being revoked.

As a general rule, an employer is only liable for sexual harassment after the victim complains and only to the extent the employer's response to the complaint was ineffective to stop it.

In this case, however, the jury concluded that hospital management was fully aware of and therefore was liable for the physician's conduct before the nurse actually filed her complaint. **Bianco v. Flushing Hosp. Med. Ctr., 2009 WL 839234 (Sup. Ct. Queens Co., New York, February 23, 2009).**

Sodium: Nurse Gave Too Much Saline, Too Quickly, Patient Sustained Brain Injury.

The fifty-seven year-old patient was brought to the emergency room by her daughter.

The patient was obviously confused and had difficulty keeping her balance.

Her history revealed she was taking a diuretic for high blood pressure. Lab tests showed she had low serum sodium. The physicians decided to replenish her sodium with IV saline.

The plan was for saline to infuse at 125 mL per hour. The emergency room nurse, however, infused a whole one-liter bag in one hour. After the one hour the patient's serum sodium reportedly was 23 mEq higher than before.

The patient was admitted when she began showing neurological deficits and eventually went to brain-injury rehab.

The emergency department nurse gave the patient a whole liter of IV saline solution in one-hour, causing her serum sodium to jump 23 mEq.

The patient suffered permanent brainstem damage in the form of central pontine myelinolysis.

After leaving specialized rehab the patient lives at home and must rely on home care.

COURT OF COMMON PLEAS
ALLEGHENY COUNTY, PENNSYLVANIA
February 5, 2009

The jury in the Court of Common Pleas, Allegheny County, Pennsylvania awarded cash and a lifetime annuity, total value in excess of $5,000,000.

The experts faulted the nurse, the hospital's practices for training and supervising nurses and the treating physicians as well. Sodium replacement must be monitored carefully so as to occur gradually, at a rate not to exceed 10 to 12 mEq in the first 24 hours, they said.

An error apparently occurred in transcription of the physician's order into the patient's chart, but the experts testified that the nurse nevertheless should have spotted the order for too-rapid sodium infusion as a mistake and not gone ahead without clarification. **Pfeifer v. Chughtai, 2009 WL 754809 (Ct. Com. Pl., Allegheny Co., Pennsylvania, February 5, 2009).**