LEGAL EAGLE EYE NEWSLETTER

May 2011 *For the Nursing Profession* Volume 19 Number 5

Post-Surgical Care: Jury Faults Nurses For Patient's Death After Coronary Bypass.

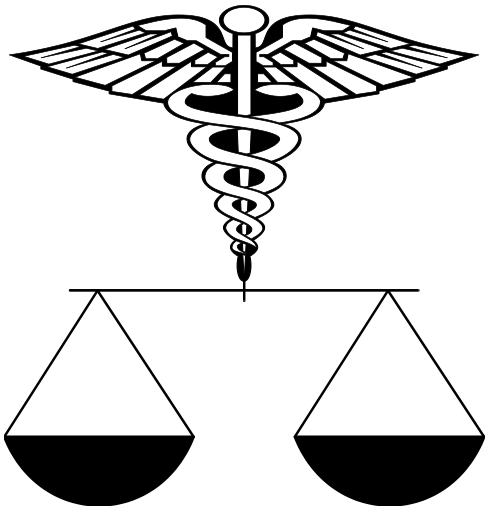
After a stress test and an abnormal echocardiogram the patient's angiogram revealed 95% blockage in the left main coronary artery and 100% blockage of the mid-portion of the right coronary artery. The patient's cardiologist referred him to a cardiothoracic surgeon for evaluation.

The surgeon performed coronary artery bypass surgery the next day without complications. The patient was stable and able to talk shortly after he got to the hospital's intensive care unit.

At 5:00 p.m. in the ICU the next day after surgery the BP dropped to 81/53. The nurses reportedly decided to wait for another reading outside the parameters specified in the surgeon's post-operative orders before calling him. At 6:00 p.m. the BP was 79/45. The nurses called and got an order for albumin which seemed to correct the problem for the time being.

Patient's Vitals Outside Parameters ICU Nurses Did Not Call Physician

At 10:00 p.m. the systolic fell to 89. At 12:00 a.m. the BP was 80/56, pulse 90+ and the lungs were clear. At 2:00 a.m. the BP was 81/55, at 5:00 a.m. 89/68. Still no call was placed to the surgeon even though the patient was less responsive and was falling asleep, complaining of chest tightness and not putting out hardly any urine.



After coronary artery bypass surgery the cardiothoracic surgeon left orders for the nurses in the intensive care unit to call him if the patient's heart rate fell below 60 or rose above 120, if the systolic pressure fell below 90 or rose above 150, if the respirations rose above 28 or if the urine output fell below 30cc per hour.

COURT OF APPEALS OF INDIANA
April 4, 2011

The surgeon's PA came in to see the patient at 7:00 a.m. on routine rounds. The surgeon came in at 9:30 a.m. and ordered blood tests and an echocardiogram. Then he had the patient sent to the cardiac catheterization lab where the patient soon expired from what was described in the court record as an anoxic cerebral event.

The Court of Appeals of Indiana endorsed the jury's verdict against the hospital for the ICU nurses' negligence which, in the opinion of a cardiothoracic surgeon called to testify as an expert witness on the family's behalf, caused the patient's death.

The patient would still be alive if the nurses had phoned the patient's cardiac surgeon right away when the vital signs fell outside the parameters the surgeon specified when the patient went to the ICU, the expert testified.

An experienced cardiothoracic surgeon could have intervened and saved the patient's life if promptly notified by the patient's nurses of the true status of the patient's post-operative progress.

A medical review panel had also concluded before the lawsuit was filed that the hospital, not the treating physicians, was responsible for the patient's death. **Elkhart General Hosp. v. Williams, 2011 WL 1233648 (Ind. App., April 4, 2011).**

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May 2011

New Subscriptions
See Page 3

Post-Surgical Nursing Care/Coronary Artery Bypass - EMTALA
Nurse Practitioner/Strep Infection/Misdiagnosis - Patient's Fall
Jail Nursing/Suicide - Reasonable Accommodation/Light Duty
Anxiety Disorder/Disability Discrimination - Drug Screen
Sexual Harassment/Patient vs. Caregiver - Skin Care/Documentation
Feeding Tube - Labor & Delivery Nursing/Fetal Heart Monitor
Nurse As Patient Advocate/E.R./ICU - Neonatal Nursery
Needlestick/Sharps - Choking Death - Insubordination/Care Issues

EMTALA: Patient Wrongfully Sent Home To Have Miscarriage.

At sixteen weeks the mother called the E.R. when she started having contractions, as her ob/gyn had instructed her.

She was told she could come in if she wanted, although there was probably nothing they could do for her. After waiting an hour she had her husband drive her to the hospital, more than an hour's drive from their rural home.

She spoke with two nurses and the admissions clerk. The E.R. physician spoke with her, did an ultrasound and then told her he was unable to get a heartbeat. An ob/gyn came in, did another ultrasound, performed a pelvic exam and confirmed that her baby had died.

The ob/gyn told her she was not dilated enough to deliver the dead fetus, so he sent her home. No mental health or social work services were offered. The ob/gyn threatened to call hospital security if the husband refused to leave and stop insisting they call the patient's own ob/gyn.

The patient at this point reportedly was still terrified by what was going on and was still feeling waves of increasing abdominal pain.

EMTALA Violation Found
Jury Verdict Upheld

The US District Court for the District of Maine refused to disturb the jury's award of $200,000 for the patient.

The Court based its decision on the testimony of two nurses who were called to testify on the patient's behalf over the hospital's strenuous objections.

The nurses' testimony established that the patient still faced considerable danger of medical complications delivering a stillborn fetus at home, her home being more than a hour's drive away from the hospital.

That satisfied the legal standard that the patient was still in the throes of the emergency medical condition which brought her to the E.R. and had not been medically stabilized by delivery of the live or dead fetus and the placenta.

The nurses' testimony also elaborated for the judge and jury on the acute psychosocial aspects of the patient's needs which in the Court's opinion were callously ignored by the physicians in the E.R. **Morin v. Eastern Maine Med. Ctr., 2011 WL 1158386 (D. Me., March 25, 2011).**

The US Emergency Medical Treatment and Active Labor Act (EMTALA) does not distinguish between viable and non-viable pregnancies.

For a pregnant woman having contractions an emergency medical condition exists as long as transfer or discharge from the emergency department may pose a threat to woman's health or safety.

The hospital's obligation with respect to a pregnant woman having contractions is to stabilize her condition by delivering the fetus and the placenta, or, after a reasonable time for observation, to have a medical professional certify that the woman is in false labor.

One risk faced by a woman who delivers a nonviable fetus at home is the risk of hemorrhaging without medical supervision and having no means to stop the bleeding.

There is also a considerable danger of emotional damage, including postpartum depression.

After spending the day at home worrying about her impending miscarriage, she sent her husband out of the bathroom and miscarried alone on the floor.

UNITED STATES DISTRICT COURT
MAINE
March 25, 2011

Strep Infection: Misdiagnosis By Nurse Practitioner Leads To Large Settlement.

The patient received a settlement of $1,000,000 after having to have aortic valve replacement surgery after a lengthy and complicated bout with a bacterial infection.

Any details of the case which could possibly lead to identification of the patient or the defendant clinic or nurse practitioner are to be kept confidential according to the terms of the settlement.

Lab tests ordered by the clinic nurse practitioner came back positive for Strep viridans.

Strep viridans is often associated with bacterial endocarditis, a condition entirely consistent with the patient's ongoing symptoms which were not yielding to the packet of antibiotics that she was being given.

SUPERIOR COURT
WASHINGTON
November 7, 2010

The gist of the negligence case against the nurse practitioner was that she neglected to do the research to make herself aware of the true nature of the bacterial infection which was revealed several times by the blood tests she was ordering.

The nurse practitioner apparently confused *Strep viridans* which showed up on the test results with *Staph aureus*, a bacterium common on the skin which can show up as a stray contaminant in lab draws.

Had the true nature of the infection been discovered in time it could have been treated with specific antibiotics and the patient would not have suffered heart complications. **Confidential v. Confidential, 2010 WL 6442667 (Superior Court, Washington, November 7, 2010).**

Falls: Inadequate Care Leads To Death, Big Verdict.

The ninety-nine year-old dementia patient reportedly fell eleven times in the nursing home before her final fall which resulted in a neck fracture at C-2.

Surgery was not done because of her advanced age. She lingered in the hospital for seven months in a neck brace during which time she developed bed sores and eventually died from a stroke.

Even though she fell eleven times before the last time there were no specific fall precautions undertaken.

The family's attorneys argued in court before the jury that she should have been given stepped-up supervision and bed and chair alarms and soft mats should have been placed on the floor at her bedside.

Right before her last fall she had just been placed on the locked Alzheimer's unit, but no one reportedly checked on her for more than two hours before she was found on the floor in her room in a puddle of blood with a gash on her forehead, black eyes and a broken neck.

The jury in the Circuit Court, Broward County, Florida awarded damages to the family of $2,395,828 including $145,828 for the medical bills for treatment during her last hospitalization. **Pagano v. Hillsborough Management, 2011 WL 1113122 (Cir. Ct. Broward Co., Florida, February 23, 2011).**

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

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

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

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Suicide Risk: Nurse Failed To Act Based Upon Patient's Screening.

The agency is wrong to argue that its employee, the jail nurse who handled this inmate's intake, did not have actual knowledge that the inmate in question was a suicide risk.

The inmate answered "yes" to ten of the items on the suicide screening form he filled out at jail intake.

Ten affirmative responses is more than enough, under jail policies mandated by state law, to trigger constant close suicide watch.

The nurse knew of and disregarded an excessive risk to the inmate's health an safety which posed immediate danger.

It was not unreasonable, given the evidence in the case, for the jury to hold the nurse's employer 35% responsible for the million-dollar plus verdict in favor of the inmate's family.

UNITED STATES COURT OF APPEALS
SECOND CIRCUIT
April 13, 2011

An agency had the contract with the local county government to provide nursing care to inmates of the county jail.

The contract made the agency responsible for screening inmates at the time of intake, reviewing intake forms filled out by inmates and monitoring and referring inmates with mental-health issues.

The agency was required to make its nurses aware of New York state minimum standards for supervision of jail inmates who posed a suicide risk.

Patient's Answers To Suicide Screening Mandated Close Supervision

The inmate answered "yes" to enough of the questions on his intake form pertaining to suicide ideation to trigger a need for constant suicide monitoring.

The agency nurse handling his intake medical screening signed her name at the bottom of the front page of the packet of forms for the inmate's intake medical screening, including the suicide questionnaire, indicating that she had reviewed all of the information.

However, the nurse did not initiate close monitoring of the inmate for suicide. He committed suicide in the jail.

The US Court of Appeals for the Second Circuit upheld the jury's verdict that the agency, the nurse's employer, was partially to blame for the patient's death. The bulk of responsibility was, however, apportioned to the county itself.

The nurse knew the patient was a suicide risk and did not advocate for safety measures as was her professional responsibility. **Sinkov v. Americor, Inc., 2011 WL 1395298 (2nd Cir., April 13, 2011).**

Light Duty: Court Sees No Reason Not To Continue Reasonable Accommodation.

The aide was hired in 1988 in a six-hundred bed long term care facility.

She had two work-related knee injuries for which she got worker's compensation. After the second knee injury she was placed on a modified-duty program where she passed ice water, took and recorded temps, stripped and made beds, passed food trays, washed and shaved residents, but was not required to do heavy lifting.

After she had been on modified duty for thirteen years her employer, as a cost cutting measure, started a new policy limiting modified duty to six months maximum.

She was told to transition to regular duty or quit.

After thirteen years in the modified-duty nurses aide position without being required to do any lifting it is unclear why lifting ability suddenly could become an essential function of this employee's job.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
February 14, 2011

The US District Court for the Western District of Pennsylvania noted for the record that the employer did not dispute that the aide was genuinely disabled.

The real issue was reasonable accommodation, whether this employee could fulfill the essential functions of her position as an aide even though disabled.

The employee's job description as defined by the employer is not the definitive answer to the question whether lifting is an essential function. After thirteen years of valuable service in modified duty status the Court was highly suspicious of the idea that the facility could not find a job for her with her medical restrictions. **Zombeck v. Friendship Ridge, 2011 WL 666200 (W.D. Pa., February 14, 2011).**

Anxiety Disorder: Court Finds No Disability Discrimination.

The US District Court for the Middle District of Pennsylvania reviewed the convoluted facts of an LPN's disability discrimination lawsuit against her former employer, a nursing home.

The LPN refused to give in to the facility's policy of mandatory overtime for all care-giving employees. She provided a letter from her psychiatrist verifying that she had a disability, an anxiety disorder, which made her prone to anxiety attacks.

The facility exempted her from mandatory overtime, but then let her go when she became pregnant and her physician would not permit her to lift more than ten pounds and she was not eligible for Family and Medical Leave Act leave because she had not been on the job a year.

The Court will assume for the sake of argument that the facility terminated the LPN's employment because she refused mandatory overtime on the basis of a verified disability, her anxiety disorder.

Even if that is so, overtime was mandatory for all employees and one employee's inability to work overtime would be a legitimate, non-discriminatory reason for terminating that employee's employment.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
April 12, 2011

The evidence presented in court by the LPN did not make it exactly clear why she was terminated. Even if it was because of her disability her employer had a legitimate, non-discriminatory reason behind the action that it took, the Court said. **Dulina v. Hometown Nursing and Rehab, 2011 WL 1376242 (M.D. Pa., April 12, 2011).**

Insubordination: Aide's Firing Upheld By Court.

A CNA was fired from her job for refusing to give a patient a shower as she was instructed by a nurse.

The CNA based her refusal on two reasons, which she communicated to the nurse: the patient was sick with cramps and vomiting; the patient refused a shower.

The CNA sued claiming her termination went against public policies against mistreatment of vulnerable patients.

The aide's refusal to shower the patient based on her disagreement with the nurse over the patient's best interests is common, garden-variety insubordination.

UNITED STATES DISTRICT COURT
NEVADA
March 30, 2011

The US District Court for the District of Nevada dismissed her case.

According to the Court, it is not necessarily wrong to give a patient a shower just because the patient has signs or symptoms of illness.

A certified nursing assistant does not have the education and training comparable to that possessed by a licensed practical nurse or registered nurse to be able to dispute the nurse's judgment as to what is in the best interests of a patient.

A CNA flat-out refusing to follow direction from an LPN or RN on a patient-care issue is common, garden-variety insubordination, the Court said.

In this case the CNA did not have an employment contract or a union collective bargaining agreement.

As a common-law employee-at-will she had no legal protection against being fired on the spot at her supervisor's discretion, regardless of the reason, assuming she was not being fired for refusing to perform an illegal act or an act which went contrary to public policy, which was not the situation in this case. **Andrews v. HCR Manor Care, 2011 WL 1303230 (D. Nev., March 30, 2011).**

Failed Drug Screen: Court Dismisses Minority Nurse's Racial Discrimination Lawsuit.

A minority nurse took oxycodone at home in the a.m. for pain in her legs before reporting to work at the hospital.

Shortly after coming on duty she became dizzy and nauseated. She told the other nurses she needed help as she sat down on the floor. They could see she was somewhat stuporous. She was taken to the hospital's E.R. in a wheelchair.

After returning to her unit from the E.R. she was still dizzy, unsteady and shaking. The charge nurse sent her to the hospital lab for a blood draw for a drug screen. It was positive for oxycodone.

Almost a month later, after the hospital lab results were confirmed by a forensic laboratory, the nurse was sent a letter requiring her to verify that she had a then-current prescription for the oxycodone which was found in her system.

The nurse had told her charge nurse that morning that the hydrocodone she had taken was prescribed for her by her dentist after a tooth extraction three years earlier.

When she was informed that it was oxycodone found in her system the story was that the pills had been prescribed for her adult daughter.

No Racial Discrimination

The US District Court for the Western District of Oklahoma dismissed the racial discrimination lawsuit the nurse filed against the hospital over her termination.

The Court validated the hospital's substance abuse policy which, among other things, forbids an employee's use of a controlled substance without a valid prescription.

One condition of employment at the hospital was that employees must refrain from illegal drug use on or off the job. The definition of illegal drug includes any drug which is not legally obtained, any drug which was legally obtained by a person other than the employee or a drug which is being used in a manner or purpose other than as prescribed for the employee.

The hospital had the right to have a policy requiring any employee to undergo alcohol or drug testing if the hospital had reasonable suspicion that the employee was under the influence or had used substances contrary to the hospital's policy.

Title VII of the US Civil Rights Act makes it unlawful for an employer to discharge any individual because of the individual's race, color, sex or national origin.

To prove a prima facie case of racial discrimination the terminated employee must show that:

1. He or she is a minority;

2. He or she was qualified for the job;

3. Despite his or her qualifications, the employee was terminated; and

4. The employee was terminated under circumstances which give rise to an inference of unlawful discrimination.

Even if all four elements are ostensibly present, the employer can still defend the lawsuit successfully by showing a legitimate, non-discriminatory rationale for the action taken against the minority employee.

Testing positive for a prescription medication for which she did not have a current authorized prescription is the reason why this employee was initially suspended on the day she tested positive and the same reason she was finally terminated after all the relevant facts were verified.

UNITED STATES DISTRICT COURT
OKLAHOMA
March 31, 2011

Reasonable suspicion of substance use means physical symptoms or other manifestations of being under the influence, including abnormal conduct or erratic behavior.

The Court was satisfied from careful review of the evidence that her supervisor had reasonable suspicion to send the nurse to the hospital's lab for a blood draw. The sample was properly labeled and stored in the hospital's lab and transmitted to the forensic laboratory in the correct manner to preserve the legal chain of custody. There was no reasonable doubt that the sample tested at the forensic laboratory was hers.

The nurse admitted at least three times that she took pills which were a controlled substance and did not have a valid prescription at the time she took them which allowed her to take them for pain in her legs. It was not relevant that she believed that admitting that to the board of nursing would help rather than hurt her on the issue of keeping her license.

Non-Minority Nurses Were Not Fired
No Basis For Comparison

Several non-minority nurses at the hospital were not fired after testing positive for alcohol or controlled substances on the job, a fact the nurse in this case brought up in her defense.

A minority employee can claim discrimination for being disciplined on the job more harshly than a non-minority employee for the same offense, even if the punishment nevertheless fits the crime for the offense committed. That is the general rule, the Court pointed out.

In this case, however, all of the non-minority employees pointed out for comparison were nurses who admitted to substance-abuse problems and submitted to supervised rehab programs before returning to work at the hospital.

The nurse herself never admitted to a substance-abuse problem and never entered rehab. According to the Court, that meant the non-minority employees she pointed out who were allowed to keep their jobs after they violated the hospital's substance-abuse policy were not a valid basis for comparison. **Burton v. Midwest Reg. Med. Ctr., 2011 WL 1300892 (W.D. Okla., March 31, 2011).**

Sexual Harassment: Court Sees Harassment But Finds No Excuse To Abuse The Patient.

The aide had grounds to sue her former employer for sexual harassment from a resident while she was still on the job at the nursing home, the US Court of Appeals for the Tenth Circuit ruled.

Even so, the facility had the right to terminate her after she lashed out verbally against the resident when she could no longer tolerate the situation.

Facility Knew of the Resident's Propensity for Abuse

The resident had criminal charges pending against him from domestic abuse, assault and battery and violation of a protective order when he was admitted to the facility. Staff transported him to and from his court dates on numerous occasions.

Resident Began to Harass the Aide

The resident seemed to be attracted to the aide in question. He acted out when she was not assigned to care for him.

It is a red flag when a resident who has been observed interacting inappropriately with staff members requests a specific caregiver, the Court said, but his requests were nevertheless granted with the proviso that two staff persons were to be in the room with him at all times.

Even with the second aide present the resident still fondled the aide routinely and made sexually explicit comments.

The aide complained to the directors of nursing and social services, but all that was done was to add language to the care plan that the resident would be discouraged from asking for a specific aide.

Eventually he physically assaulted her. He grabbed her and held her down so that she could not get up until he let her. He was later convicted of criminal charges.

The assault was followed by a tirade of verbal provocation in the dining room claiming she had withheld his medications.

Aide Admitted Verbal Abuse

The aide was called in to the administrator's office the next day. He was not aware of her ongoing complaints of sexual harassment. When she admitted she called the resident a "prick" during his tirade the administrator fired her for patient abuse. **Aguiar v. Bartlesville Care Ctr., 2011 WL 1461541 (10th Cir., April 18, 2011).**

The resident routinely subjected the aide to unwanted touching, interfered with her work and finally assaulted her. The resident was eventually convicted of assault and battery for attacking the aide.

However, the employer nevertheless had a legitimate, non-discriminatory reason for firing the aide.

Verbal abuse of a patient by a care-giving employee is never excused.

The facility's employee handbook explicitly warned that verbal abuse of a resident was grounds for immediate termination. The facility's policy in this regard is perfectly legal.

Sexual harassment can be seen in a hostile work environment where the harassing conduct, from a client of the employer or from a co-worker, is sufficiently severe or pervasive to alter the terms and conditions of the victim's employment and create an abusive working environment.

To be the basis for a lawsuit the offensive conduct must be frequent, severe and physically threatening or humiliating, not just offensive.

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT
April 18, 2011

Skin Care: Large Verdict For Nursing Negligence.

The patient was fifty-five years old when he was hospitalized for hip surgery.

He developed bed sores on his heels during a re-admission to the hospital from a nursing home to treat an infection of the surgical wound. The lesions took more than fourteen months to heal.

The hospital's nurses failed to identify the risk of pressure sores and put in place a pressure ulcer prevention protocol.

The patient should have been repositioned regularly and boots provided for the heels to relieve pressure.

His nutrition was not monitored, nor were supplements provided as ordered by his physician.

The medical chart was doctored in some places to indicate there were no sores while other entries indicated the sores were being treated, both of which were false statements.

DISTRICT COURT
SAN MIGUEL COUNTY, NEW MEXICO
February 18, 2011

The jury in the District Court, San Miguel County, New Mexico awarded the family $10,345,000 in a trial which took place two years after the patient had died from causes unrelated to his pressure sores.

$9,750,000, the bulk of the verdict, was punitive damages. The jury reportedly flatly rejected the argument that the inconsistencies in the chart were mere documentation errors as opposed to intentional falsifications. **Gonzales v. Christus St. Vincent, 2011 WL 1491815 (Dist. Ct. San Miguel Co., New Mexico, February 18, 2011).**

Nutrition: Feeding Tube Refused By Family, Court Finds No Nursing Negligence.

The elderly patient was transferred from the hospital to a nursing home where his existing Stage I-II sacral decubitus ulcer progressed to Stage IV, his weight declined and he eventually died from sepsis.

The patient's son had sole legal authority to consent or refuse a feeding tube on his father's behalf.

He was advised otherwise but consistently refused.

UNITED STATES DISTRICT COURT
NEW YORK
March 23, 2010

The patient's son sued for negligence after his father died. The son's expert witness, a physician, pointed out the necessity of good nutrition in the care of skin lesions in elderly bedbound patients, which in this case meant a feeding tube for this patient.

The son, however, repeatedly refused to give his consent to a feeding tube and he was the only person with legal authority to give consent on the patient's behalf.

The US District Court for the Southern District of New York was satisfied the nursing facility fulfilled its legal obligations to this patient.

Starting at the time of admission, the nursing progress notes in the chart documented that the nurses and the dietician repeatedly advised the son that good nutrition was important to the patient's overall health and necessary if his skin lesion was going to heal.

An unhealed lesion could progress to a more invasive lesion involving the underlying tissues which could lead to fatal sepsis, the son was repeatedly informed.

In addition, the facility got the patient a pressure relieving mattress on admission and then switched to another model that was better, removing that as another potential legal issue. **Kushner v. US, 2011 WL 1201936 (S.D. N.Y., March 23, 2011).**

Labor & Delivery: Nurses' Inaction Leads To Large Settlement.

The thirty-two year-old patient's prenatal workup pointed to a normal healthy baby.

She checked into the hospital at 1:30 a.m. in the first stage of labor and a fetal heart rate monitor was started.

Nurses Watching the Monitor Waited to Call the Obstetrician

At 9:32 a.m. the fetal heart rate suddenly dropped from a normal 140 to a dangerously low 60 beats per minute.

In the course of the resulting lawsuit the hospital's telephone records were subpoenaed to prove that there was a delay of almost thirty minutes from the time the monitor data became ominous before a call was placed to the patient's obstetrician's residence.

The obstetrician testified he was not actually called until 10:10 a.m.

It took the obstetrician twenty-five minutes to get to the hospital. Then another twenty minutes was wasted, allegedly due to the fact no anesthesiologist was available.

Once the emergency c-section was started the baby was delivered in under five minutes. It appeared that a compressed umbilical cord had been depriving the fetus of oxygen and that accounted for the low heart rate.

The hospital, the obstetrician, the labor and delivery nurse and the labor and delivery nursing supervisor were all sued in the Superior Court, Hudson County, New Jersey. The lawsuit alleged negligence for the unaccountable delay between the first recognition of signs of fetal distress and the emergency cesarean delivery.

Five days into a jury trial the hospital's insurance company agreed to pay a $8,500,000 settlement.

$6,000,000 will cover the child's special needs and $2,500,000 went directly to the parents. The child, now almost six, is blind, cannot walk, is subject to seizures, can only take liquid nutrition through a straw and requires constant care. **Ordonez v. Bayonne Med. Ctr., 2011 WL 1491775 (Sup. Ct. Hudson Co., New Jersey, March 21, 2011).**

Nurse As Patient Advocate: Court Looks At Standard Of Care For E.R., ICU Nurses.

There has been no definitive ruling one way or the other whether the nurses were at fault.

The Court of Appeals of Texas has ruled merely that the patient's estate's expert witnesses have correctly articulated the pertinent legal standard of care.

The fifty-one year-old patient was admitted to the ICU from the E.R. and died the next day from pneumonia brought on by a *Staph* infection.

Emergency Room Nurses

The estate's nursing expert's opinion was that emergency room nurses must make a comprehensive nursing assessment of the patient's health status, make nursing diagnoses and formulate a plan of care.

In this case that translated into appreciating the significance of the patient's medical history of *Staph* infection and signs and symptoms of systemic sepsis, including rapid breathing, rapid heart rate and low O_2 saturation.

The required action was for the E.R. nurses to make the physicians aware of the nature of the patient's difficult condition.

Intensive Care Nurses

The estate's medical expert's opinion was that the ICU nurses should have impressed upon her physicians the nature of her condition and advocated for different interventions.

In more specific terms that meant the nurses should have been watching her to see if the antibiotic Levaquin, often used in cases of *Strep pneumoniae*, was proving effective, should have realized it was not working to stem her *Staph* infection and should have advocated for orders for a broad-spectrum antibiotic.

Any reasonable ICU physician, the expert went on to say, would have changed the antibiotic, and that, more likely than not, would have successfully stemmed the relentless *Staph aureus* infection in the patient's system and saved the patient's life. **Christus-Spohn Health System v. Cervantes, 2011 WL 1159961 (Tex. App., February 10, 2011).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Babies Switched In Nursery: Parents' Lawsuit Dismissed.

The parents' newborn baby spent her first night in the hospital's newborn nursery.

The next morning the nursery nurses put the baby with another maternity patient and put the other patient's baby with the mother in question.

Their baby was reportedly nursed by the other patient before the error was discovered and the babies were returned to the beds of their own actual mothers.

The parents filed a lawsuit against the hospital alleging extreme emotional pain, mental suffering and anxiety.

The New York Supreme Court, Appellate Division, dismissed their case.

Even if their baby somehow suffered a physical or emotional injury as a result of being nursed by a stranger who was not her own mother, for which there was no proof whatsoever, the baby's parents would not have grounds to sue for their own mental distress or emotional distress, as they themselves were not injured in any way by what happened. **Williams v. Long Island College Hosp., __ N.Y.S.2d __, 2011 WL 1440310 (N.Y. App., April 22, 2011).**

Needlestick: Worker Awarded Damages.

An inmate with a job in the prison medical dispensary was stuck in the thumb of his right hand by a vacuum needle that was used earlier that morning to draw blood from another inmate and then thrown in the recycling rather than the sharps disposal container.

The dispensary nurses milked blood from the puncture site, swabbed it, applied Betadine, put on a Band-Aid and gave the inmate a tetanus shot. After a few days the nurse in charge of infection control verified that the inmate with whom the needle had been used was not infected with HIV or hepatitis.

The injured inmate was nevertheless tested after a few days and again at three months and six months. Everything was negative.

The inmate sued for $300,000. The Department of Corrections admitted fault and an arbitrator awarded the patient $7,500 for his physical injury and the mental stress he suffered worrying for a time if he was infected.

The money awarded to the inmate was claimed by the state's Crime Victim Restitution Fund as partial payment of his debt. **Gohl v. State of Wash., 2010 WL 6442662 (Arbitration, Spokane Co., Washington, December 16, 2011).**

Choking Death: Court Finds Evidence For The Family's Negligence Lawsuit To Go Forward.

The sixty-eight year-old nursing home resident had alcohol-related dementia and complications from a stroke. He could not speak and had difficulty swallowing.

He choked on his dinner in the dining room. Before he died several nursing home employees tried the Heimlich maneuver and paramedics removed pieces of food from his trachea.

The family's lawsuit alleged the nursing home failed to set up a suitable care plan, failed to change or adjust the care plan as needed and failed to provide adequate staffing.

The resident's family's expert witness was a registered nurse on the malpractice side of the case, the care planning and staffing issues. The facility's expert witness was a physician. The New York Supreme Court, Appellate Division, accepted the physician's opinion that the facility's care planning for the resident and the staffing levels fully met the standard of care.

The incident report revealed that the CNA assigned to supervise the resident in the dining room was passing trays to other residents when the resident choked on his food.

The resident may have had a heart attack or a stroke right before he died, as the facility claimed, but that is not necessarily inconsistent with choking as the cause of death.

NEW YORK SUPREME COURT
APPELLATE DIVISION
April 1, 2011

However, family's lawsuit still had legs to stand on. The charge nurse's incident report revealed that the CNA who was supposed to be closely supervising this resident while he ate was passing trays to other residents.

A non-licensed staff member's failure to follow simple explicit directions from the physician to supervise a resident closely who is eating does not involve an error or omission in the exercise of professional judgment.

The law's name for that is ordinary negligence which, unlike professional negligence, does not require expert testimony to prove to a jury. **Carthon v. Buffalo Gen. Hosp., __ N.Y.S.2d __, 2011 WL 1219255 (N.Y. App., April 1, 2011).**