LEGAL EAGLE EYE NEWSLETTER

November 2007 *For the Nursing Profession* Volume 15 Number 11

Whistle Blowing: US Courts Restrict Nurses' Rights, Give Their Employers Wider Latitude.

The US District Court for the District of Colorado has ruled that a 2006 US Supreme Court decision does apply to nurses.

In 2006 the Supreme Court sharply restricted the right of a public employee to claim free-speech protection under the First Amendment for speaking out on a subject of public concern that falls within the scope of the public employee's duties as a public employee.

Nurse's Primary Responsibility Was Patient Safety and Welfare

The nurse in this case claimed she was terminated in retaliation for her complaints to her superiors and for allegations she raised in occurrence reports relating to inadequate staffing and various mix-ups in the hospital heart-transplant unit where she worked.

Even if her claim is true that she was a victim of retaliation, the court said, the First Amendment does not give the nurse the right to sue her former employer for violation of her Constitutional rights, as those rights are now defined by the US Supreme Court.

The essence of the court's ruling is that the nurse was not speaking out as a private citizen voicing concerns about a subject of public concern, but as a public employee whose official duty was to deal with the subject matter.

The hospital's argument is correct that a recent US Supreme Court decision does apply to nurses and does restrict nurses' right to claim whistle blower protection for speaking out in some circumstances.

Was the nurse speaking out within the scope of the nurses' job responsibilities. If so, the nurse is not a whistle blower.

UNITED STATES DISTRICT COURT
COLORADO
October 16, 2007

The nurse in question, according to the court, drafted and circulated numerous occurrence reports documenting nursing errors and so-called "near misses" as part of a wider campaign she had undertaken to demonstrate to hospital management that patient care was being endangered by insufficient nurse staffing on the unit.

The court ruled it was irrelevant whether these were legitimate issues of public concern. The relevant point was that this was part of her official duties as a nurse. That was true whether or not her job description formally allowed her to draft occurrence reports or delegated responsibilities to her for quality assurance.

The nurse also reported to an organ-procurement organization that the hospital tried to cover up an alleged incident of a heart meant for one patient actually being given to a different, mismatched patient.

Even if that really happened, the court said, and even if monitoring procurement and allocation of transplant organs was not one of the nurse's official job functions, it still related in general terms to the nurse's job as a nurse on the transplant unit.

Speaking out not as a private citizen but as an employee of the transplant unit, her self-expression did not come under the First Amendment. **Rohrbough v. Univ. of Colorado Hosp., 2007 WL 3024449 (D. Colo., October 16, 2007).**

Inside this month's issue ...

November 2007

New Subscriptions
See Page 3

Patient Abandonment: Court Agrees With Nursing Board, Upholds Disciplinary Action.

An LPN was employed by a nurse-staffing agency with a contract to provide nursing personnel for a hospital's med/surg unit.

On the 7:00 p.m. to 7:00 a.m. shift she was assigned five patients. One had COPD. One was recovering from surgery. Another was a prenatal patient on the med/surg unit with a fetal heart monitor. All the patients were basically stable, except the prenatal patient for whom the LPN was trying to get an obstetrician to come to the unit for an exam and consult.

The LPN became ill between 4:30 and 5:00 a.m. She vomited in the bathroom. She went to the nurses station and told the four other nurses on duty that she was leaving.

The charge nurse told her to find the house supervisor before exiting the premises. She was to inform the supervisor she was leaving before the end of her shift.

The LPN did not communicate with the nursing supervisor. She gave as her reason that she did not want to be sent to the emergency room and billed for an emergency-room visit. She claimed she intended instead to see her family physician first thing in the morning.

The next day the hospital informed the staffing agency they were terminating the LPN's contract. The hospital reported the LPN to the state Board of Nursing.

The Court of Appeals of Tennessee agreed with the Board that the LPN wrongfully abandoned her patients and upheld the $1000 penalty the Board imposed. The most telling factor was that the LPN's assigned patients were indeed in need of nursing care when she walked out on them.

The Court, however, overruled the Board's suspension of her license pending a psychological evaluation. There was no basis for the Board to suspect from her conduct that the nurse had a psychological condition that affected her fitness to practice as a nurse. **Miller v. Tennessee Bd. of Nursing, 2007 WL 2827526 (Tenn. App., September 26, 2007).**

A nurse-patient relation ship begins when a nurse accepts responsibility for a patient's nursing care.

For a nurse to be guilty of patient abandonment, the nurse must:

Accept the patient assignment, thus establishing a nurse-patient relationship; and then

Sever the nurse-patient relationship without giving reasonable notice to the appropriate persons, that is, a supervisor and the patient, so that arrangements can be made for continuation of nursing care by others.

The courts have softened the definition of abandonment somewhat.

The courts say that abandonment does not occur unless the nurse's patient or patients actually require nursing care before another nurse is able to take over.

Four of this nurse's patients were scheduled to receive medications they did not get on time because she left before the end of her shift. A fifth patient was in early labor on a fetal heart monitor which had to be watched by a trained person.

COURT OF APPEALS OF TENNESSEE
September 26, 2007

Agency Nurse: Facility Bound By Contract If A Nurse Is Hired Directly.

An extended care nursing facility was hit with a $94,622.50 civil judgment after the facility directly hired seven nurses who had been referred to work at the facility by a nursing staffing agency.

The contract between the nursing agency and the nursing facility prohibited the facility from directly hiring any nurses sent to the facility by the agency, unless the facility was willing to pay the agency a finder's fee of 25% of the nurses' first-year annual salaries.

This arrangement is fairly standard in the industry. A judge only needs to use his or her common sense to interpret the contract in the agency's favor.

SUPERIOR COURT OF NEW JERSEY,
APPELLATE DIVISION
October 12, 2007

The facility apparently got into a dispute with the agency over the commissions it was paying for the agency's nurses, tried unsuccessfully to re-negotiate the contract, then just went ahead and hired the agency nurses directly on its own payroll.

The court found the facility in breach of contract and awarded as damages 25% of the nurses' annual salary, following to the letter the terms of the contract the facility signed with the agency. **Mercury Staffing, Inc. v. Newark Extended Care Facility, Inc., 2007 WL 2963225 (N.J. App., October 12, 2007).**

Peer-Review/Quality-Assurance Privilege: Court Reviews The Steps A Healthcare Facility Should Take Before A Lawsuit Has Materialized.

Taking proper steps ahead of time to keep internal peer-review and quality-assurance documents out of the hands of patients' lawyers is one element of solid strategy to defend lawsuits alleging malpractice.

The Court of Appeals of Texas recently handed down an ruling which summarizes the steps a healthcare facility can and should take. At this point the court has only ruled that the plaintiff's lawyers, in this case representing a nurse who was assaulted by a patient, are not entitled to a copy of the incident or occurrence report.

Committee Established

The first step is that the facility must establish one or more committees. Each committee must have a defined responsibility. That could include review of safety-related occurrences, occurrences related to physicians' credentials, occurrence related to patient-care quality review, etc. The bylaws or other pronouncement setting up the committee and defining its scope of responsibility must specify that the committee's deliberations and conclusions will be confidential.

This hospital had a safety committee responsible for developing and promoting safety standards and a safe environment for patients, visitors and employees.

One of the stated purposes of the safety committee was to review safety-related occurrence reports. The committee required an occurrence report for any unusual occurrence, accident, injury or harm, or the potential for injury or harm to any patient, visitor or employee.

The reports went to the risk manager, who presented summaries of the reports to the safety committee at its monthly meetings.

The reports were also identified by date and their general subject in the risk manager's privilege log as documents for which a legal privilege would be claimed if the matter went to court.

COURT OF APPEALS OF TEXAS
September 13, 2007

The committee must be mandated to meet and must actually meet on a regularly defined basis and must consider and make recommendations to hospital management within the scope of its responsibility.

Incident, Occurrence Reports

Incident or occurrence reports must be labeled as such and must be labeled as confidential. Merely labeling a document, however, does not ensure confidentiality.

A privilege log should be maintained by risk management or the legal department listing and identifying in general terms all incident or occurrence reports as they are received, for which the privilege of confidentiality might later be asserted.

To be confidential the incident or occurrence report, and others like it, must actually be transmitted to the appropriate committee, considered by the committee and acted upon by the committee in the regular course of its operation.

Medical records, personnel records, etc., which are prepared and maintained in the ordinary course of hospital business for a purpose other than peer review or quality assurance do not come under the peer-review or quality-assurance privilege just because they happen to be considered by one or more committees along with incident or occurrence reports that do come under the privilege.

A subpoena for documents must be honored and the judge allowed to make a decision. Ignoring a subpoena can open a Pandora's box of problems. **In re Intracare Hosp., 2007 WL 2682268 (Tex. App., September 13, 2007).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924
© 2007 Legal Eagle Eye Newsletter

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

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

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

Circle one: $155 one year $85 six months
Check enclosed ____ Bill me ____ Credit card ____
Visa/MC/AmEx/Disc No. _____
Signature _____ Expiration Date _____

Name _____
Organization _____
Address _____
City/State/Zip _____

Phone toll free
1-877-985-0977

Mail to:
Legal Eagle
PO Box 4592
Seattle WA
98194-0592

Patient Codes: Jury Finds No Nursing Negligence.

The patient was sent to a hospital med/surg unit following surgery.

The next morning she started complaining of chest pain and shortness of breath. Her nurse saw she was diaphoretic, took vital signs and notified the patient's doctor of her condition.

The nurse also let the charge nurse know what was going on with her patient. The charge nurse, in turn, called for the nursing supervisor to come to the room. While all three nurses were in the room it became necessary to call a code.

After the patient was revived she was sent to the ICU. She had suffered brain damage from lack of oxygen during the code. The family elected to discontinue life support and she died.

The jury in the Circuit Court, Madison County, Alabama returned a verdict of no negligence. **Nayman v. Huntsville Hosp., 2007 WL 2988258 (Cir. Ct. Madison Co. Alabama, February 23, 2007).**

Fall: No Nursing Negligence.

The physical therapist left the patient on the toilet and notified the nurse. The nurse went to the bathroom when the patient was ready to get up.

A walker for the patient was already close by. As she stood up and took a step toward the walker the patient's eyes rolled back and she fell forward on her face.

The jury in the Superior Court, Sacramento County, California accepted the hospital's nursing expert's testimony that this patient was not a special fall risk just because she was on narcotics post-surgery. It was an unexpected accident and no one was at fault. **Blas v. Univ. of Calif., 2007 WL 2872325 (Sup. Ct. Sacramento Co. California, August 30, 2007).**

Epidural Anesthetic: Nurse And Physician Failed To Monitor Their Patient.

A lawsuit filed in the Superior Court, Orange County, California was recently settled for $4,200,000 and reported with a stipulation that the names of those involved would be kept confidential.

Anesthetic Bolus Given
Nurse, Physician Left the Room

The thirty year-old patient's labor with her first child was not progressing, so it was decided she would have a cesarean. In preparation for her cesarean a bolus of anesthetic was delivered through the epidural catheter that had been in place during her labor.

The bolus was apparently given just before hospital personnel changed shifts. No nurse or physician stayed in the labor room with the patient.

The medical experts alleged the bolus was too large and/or leaked into the intravascular or the intrathecal space. Their testimony on this point was not conclusive. There was no doubt, however, that after the bolus was given the mother went into severe respiratory distress and that no hospital medical or nursing personnel were with her in the room when her respiratory distress began.

It was not until the obstetrician happened to look at the fetal monitor read-out at the nurses station that anyone picked up on the mother's dire status.

A crash cesarean was done and the baby was born basically unaffected by the incident.

However, the mother is now in an irreversible vegetative state. She will likely live out the remainder of her life expectancy in a skilled nursing facility. The cost of a lifetime of skilled care for her accounts for the magnitude of the settlement. **Confidential v. Confidential, 2007 WL 2983130 (Sup. Ct. Orange Co. California, August 10, 2007).**

Discrimination: Nurse Fired Without An Investigation.

A registered nurse had a spotless record working for the same hospital thirty-seven years, her only employment since nursing school, until she was abruptly fired over a written complaint filed by a nursing assistant stating that the nurse mistreated an ob/gyn patient who had a miscarriage.

Sixty-one years of age at the time of her termination, the nurse sued her former employer for age discrimination.

The evidence strongly supported the jury's verdict. There was no other rational explanation besides age discrimination.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
October 10, 2007

The US District Court for the Eastern District of Pennsylvania entered judgment against the hospital for $256,800.00.

Hospital Policy Not Followed
No Investigation

Hospital management conducted no investigation of the incident. The allegations in the nurses assistant's report were accepted at face value even though she seemed to be pointing the finger of blame at someone else for her own errors and omissions. No other witnesses were interviewed and no documentary evidence was considered, the court said.

Contrary to hospital policy, the nurse was not given the opportunity for a hearing, in which she would be entitled to legal representation, to contest the allegations.

Arbitrary adverse employment action against a minority or a person in the 40-70 year-old age bracket is assumed to be discriminatory unless the employer can show the substance and process were fair. **Scanlon v. Jeanes Hosp., 2007 WL 2972558 (E.D. Pa., October 10, 2007).**

EMTALA: Court Rules Hospital Not At Fault For Patient's Death.

A patient came to the E.R. with abdominal pain and a chronic cough. The nursing and medical staff took her vital signs, ordered blood work, tried to get an abdominal x-ray and admitted her.

The next day she was transferred to a facility better able to care for her. Upon arrival there she had a heart attack and soon died. The full gamut of diagnoses at the tertiary care facility included hypotension, left shift with leukocytosis, leukopenia, coagulopathy with DIC, left-sided pneumonia, anuric renal failure, hyperglycemia and respiratory cardiac arrest.

EMTALA requires a hospital's emergency department to provide appropriate medical screening to any person seeking assistance in the emergency department to discover if an emergency medical condition exists.

If an emergency medical condition is discovered, the hospital must stabilize the patient before discharge or transfer.

UNITED STATES DISTRICT COURT
ARKANSAS
October 5, 2007

The US District Court for the Western District of Arkansas ruled the first hospital did not violate the US Emergency Medical Treatment and Active Labor Act.

The hospital gave the patient the same standard exam any other patient would get with the same presenting symptoms, stabilized her, and only after she appeared stable transferred her to another facility for more appropriate care. **Prickett v. HSC Med. Ctr., 2007 WL 2926862 (W.D. Ark., October 5, 2007).**

MD's Explosive Outburst: Nurses Cleared Of Charges.

A motor-vehicle trauma patient, still in a room in the emergency department, was having difficulty breathing.

The E.R. charge nurse called two physicians into the room. They saw to his needs and left.

The patient once again experienced difficulty breathing, so the charge nurse called them back again. The nurse left the room to get a medication they ordered. While out of the room she invited two other E.R. nurses to come in if they wanted to watch an intubation.

When the three nurses entered the room one of the physicians went into an explosive rage, screaming, yelling and demanding a "knife," presumably for a tracheostomy. The other physician, however, vehemently disagreed with his plan for a tracheostomy and wanted to intubate through the oral cavity.

Which Orders To Follow?

The charge nurse decided to disobey the one doctor's request for a "knife" and instead to retrieve the supplies for an oral intubation per the other doctor's plan.

The charge nurse and the two others were written up on disciplinary charges at the one physician's behest.

The Court of Appeal of Louisiana, however, ruled that the charge nurse acted appropriately in the unusually chaotic situation in which she found herself and that the one physician's outburst of explosive rage was completely inappropriate.

According to the Court, the nurses judged which orders to follow based on the fact the physician whose orders they refused to follow was acting out in a very peculiar and unprofessional manner.

The idea of following the orders of a physician who was acting out basically like a mental patient made the nurses understandably uneasy for their patient's safety and wellbeing, the court said. **Lopez v. LSU Health Sciences Center, 2007 WL 2685145 (La. App., September 14, 2007).**

Dehydration: Jury Finds Nursing Home Neglected Patient's Care.

The patient had to be taken to a hospital by paramedics after her son found her in her bed lethargic and unresponsive.

At the hospital she was diagnosed with severe dehydration and a urinary tract infection. Shortly after admission she had a heart attack and died.

The family's geriatrics expert testified before the jury in the Court of Common Pleas, Allegheny County, Pennsylvania that her fatal heart attack was related to dehydration.

The family's nursing expert put together proof of substandard, negligent nursing care directly from the medical chart. On only four days during the month before she went to the hospital was there actually any charting. There was no follow-up to her physician's order for lab cultures to see if she had a urinary tract infection, and, consequently, no treatment.

The jury awarded $193,500. **Scampone v. Grane Heathcare Co., 2007 WL 2728291 (Ct. Cm. Pl. Allegheny Co. Pennsylvania, June 1, 2007).**

Fall: Bed Rails Were Left Down.

Family members told the nurse they were done visiting the patient so the nurse could raise the bed rails and turn the bed alarm back on. An hour later they got a call from the hospital that the patient had fallen out of bed, presumably because the nurse neglected the bed rails and the bed alarm.

The Court of Appeals of Wisconsin nevertheless dismissed the family's lawsuit because their lawyer did not have an expert witness. **Paullin v. Oconomowoc Memorial Hosp., 2007 WL 2728281 (Wisc. App., September 20, 2007).**

Cytotec Induction Of Labor: Nurse Midwife Cleared Of Negligence For Uterine Damage.

The mother's labor had to be discontinued in favor of a cesarean when the mother's blood pressure spiked and the fetus's heart rate dropped ominously.

During the cesarean the physician discovered the mother's uterus had been damaged and made the judgment to go ahead with a hysterectomy on the spot. The baby was born unaffected but the mother did lose her uterus.

Lawsuit Attempts to Fault Nurse Midwife's Care

The mother sued the hospital for alleged negligence by the nurse midwife who provided her prenatal care and stayed with her during induction of her labor with Cytotec, right up to the point the midwife's and the labor and delivery nurse's monitoring of her labor indicated it was time to call in the physician for a cesarean.

The Court of Appeal of Louisiana upheld the jury's verdict clearing the nurse midwife and the hospital of the allegations of negligence.

The nurse midwife did an ultrasound which showed the baby was large. The mother was showing early signs of pre-eclampsia. It was time to get her in and induce labor, the nurse midwife concluded.

The nurse midwife fully explained the mother's options and got informed consent to induce labor with Cytotec. The nurse midwife followed the hospital's medical protocol to the letter for use of Cytotec and competently monitored her patient.

Attentive monitoring of the patient by the nurse midwife and a staff nurse led to the emergency cesarean.

Damage to the uterus is one possible consequence of induction of labor, whether a nurse midwife or a physician is attending to the patient's care.

As long as informed consent is obtained and the patient is treated competently, a bad result, in and of itself, does not prove negligence by a medical or nursing caregiver. **Hypolite v. Columbia Dauterive Hosp., __ So. 2d __, 2007 WL 2851006 (La. App., October 3, 2007).**

Nurses performing medical services are subject to the same standards of care and legal liabilities as physicians.

A nurse midwife who provides prenatal care must competently assess the status of the fetus. The nurse midwife must also competently assess the mother's status, watching particularly for signs and symptoms of pre-eclampsia.

The nurse midwife who attends at the birth must meet medical standards for obtaining informed consent from the patient. This entails informing the patient of her options regarding natural vaginal delivery, methods for inducing vaginal delivery, and cesarean section. The viability and advisability of each option must be explained to the patient in light of the nurse midwife's assessment of the mother's and fetus's risk factors.

Induction of labor by a nurse midwife must adhere to the hospital's internal standards for dosage and timing, after a competent cervical exam and assessment, and must be accompanied by competent monitoring of the progress of labor.

COURT OF APPEAL OF LOUISIANA
October 3, 2007

tPA: Patient Gets Settlement For Arm Injury From IV.

The patient came to the emergency room at 4:00 a.m. with chest pains. An EKG was normal, but she was kept. At 9:00 a.m. a second EKG showed she was having a heart attack. tPA was started right away. The heart-attack symptoms subsided.

However, as she alleged in her lawsuit filed in the Supreme Court, Suffolk County, New York, the hospital nursing staff repeatedly ignored her complaints that the IV site was painful and visibly swollen. She returned to the E.R. several more times, not for her heart condition, but for the IV site.

Finally the nurses did get a vascular surgeon to come and look at the IV site. He eventually performed two surgeries. The patient now claims to have reflex sympathetic dystrophy. The settlement was $650,000 for nursing and medical delay in responding to her complaints. **Morton v. Brookhaven Memorial Hosp., 2007 WL 2850371 (Sup. Ct. Suffolk Co. New York, January 31, 2007).**

Pitocin: Nurse Midwife, $24 Million Award.

A nurse midwife at a US military hospital started Pitocin to induce labor, continued the Pitocin when the contractions rose to seven per ten minutes and increased the Pitocin when the fetal heart rate began to show marked variability, after the mother's uterus had ruptured.

The baby was born by emergency cesarean with profound birth injuries.

The judge in the US District Court for the Southern District of Illinois awarded $24,554,880 against the US government because of the nurse midwife's errors and omissions, for the baby's future life-care expenses. **Tremain v. US, 2007 WL 2791795 (S.D. Ill, May 31, 2007).**

CDC: Proposed Consolidation Of Infant Vaccine Info Statements.

On October 4, 2007 the Centers for Disease Control and Prevention put forth a proposal to consolidate the required vaccine-information statements for six vaccines commonly given to infants between birth and age six months into one consolidated vaccine-information statement.

The CDC will likely have this available sometime in late December, 2007. Use of the six separate vaccine-information statements will still be valid and acceptable after the new consolidated statement comes into use. The new consolidated statement will not change any of the CDC's current recommendations for infant vaccinations.

All of the CDC's current vaccine-information statements and recommendations for pediatric and adult vaccinations are available from the CDC at http://www.cdc.gov/vaccines/pubs/vis.

FEDERAL REGISTER October 4, 2007
Pages 56765 – 56767

Medicare/Medicaid: CMS Finalizes Regulations For Revisit User Fees.

On September 19, 2007 CMS finalized new regulations to start charging user fees for Medicare and Medicaid survey revisits.

The full-text Federal Register announcement is on our website at www.nursinglaw.com/revisituserfees.pdf.

The fee for each survey revisit conducted on-site is:
Hospitals $2,554.00;
SNF/NF $2,072.00;
Home Health $1,613.00;
Hospices $1,736.00.

The only change versus the regulations proposed June 29, 2007 is a fourteen-day, not seven-day, deadline to send CMS a letter requesting reconsideration.

FEDERAL REGISTER September 19, 2007
Pages 53627 – 53649

Sec. 488.30 Revisit user fee for revisit surveys.

(a) Definitions. Revisit survey means a survey performed with respect to a provider or supplier cited for deficiencies during an initial certification, re-certification, or substantiated complaint survey and that is designed to evaluate the extent to which previously-cited deficiencies have been corrected and the provider or supplier is in substantial compliance with applicable conditions of participation, requirements, or conditions for coverage.

Revisit surveys include both offsite and onsite review.

Substantiated complaint survey means a complaint survey that results in the proof or finding of noncompliance at the time of the survey, a finding that noncompliance was proven to exist, but was corrected prior to the survey, and includes any deficiency that is cited during a complaint survey, whether or not the cited deficiency was the original subject of the complaint.

(d) Collection of fees. (1) Fees for revisit surveys under this section may be deducted from amounts otherwise payable to the provider or supplier.

(2) Fees for revisit surveys under this section are not allowable items on a cost report, as identified in part 413, subpart B of this chapter, under title XVIII of the Act.

(3) Fees for revisit surveys will be due for any revisit surveys conducted during the time period for which authority to levy a revisit user fee exists.

(e) Reconsideration process for revisit user fees.

(1) CMS will review a request for reconsideration of an assessed revisit user fee--

(i) If a provider or supplier believes an error of fact has been made in the application of the revisit user fee, such as clerical errors, billing for a fee already paid, or assessment of a fee when there was no revisit conducted, and

(ii) If the request for reconsideration is received by CMS within 14 calendar days from the date identified on the revisit user fee assessment notice.

(2) CMS will issue a credit toward any future revisit surveys conducted, if the provider or supplier has remitted an assessed revisit user fee and for which a reconsideration request is found in favor of the provider or supplier. If in the event that CMS judges that a significant amount of time has elapsed before such a credit is used, CMS will refund the assessed revisit user fee amount paid to the provider or supplier.

(f) Enforcement. If the full revisit user fee payment is not received within 30 calendar days from the date identified on the revisit user fee assessment notice, CMS may terminate the facility's provider agreement ... and enrollment in the Medicare program or the supplier's enrollment and participation in the Medicare program.

FEDERAL REGISTER September 19, 2007
Pages 53627 – 53649

Hyperkalemia: Nurse Ignores Doctor's Orders.

Nine hours after chemo the patient was drowsy, confused and disoriented. The nurse phoned the physician to report that his potassium was 8.9 and the physician ordered Kayexalate given immediately.

After astutely reporting to the physician, however, the nurse neglected to transcribe the physician's order and never gave the medication. The patient died in the ICU three days later.

The family's lawsuit in the District Court, Ada County, Idaho settled for an undisclosed amount. **Figueredo v. St. Alphonsus Reg. Med. Ctr., 2007 WL 2749158 (Dist. Ct. Ada Co. Idaho, July 16, 2007).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Alzheimer's: Nursing Facility Not Liable For Alleged Assault On Patient.

An elderly nursing home resident, who did not suffer from Alzheimer's, cried out from her room. When the nurse ran into her room the resident was on the floor injured. Another resident of the facility, an elderly gentleman who did suffer from Alzheimer's, was also in her room.

The patient sued the facility, claiming the other resident pushed her down.

The Court of Appeals of Tennessee ruled there were no grounds for the lawsuit. Alzheimer's patients are prone to wandering with no apparent purpose; his being in her room at the time did not necessarily prove he had hurt her.

More importantly, he had no history of aggressive behavior toward other residents. Even if he did push her, the facility had no reason to anticipate he would do something like that. **Hamilton v. Metropolitan Hospital Authority, 2007 WL 2827381 (Tenn. App., September 28, 2007).**

Diversion: Nurse Fired For Giving Narcotic, Ibuprofen To Co-Worker.

An LPN who was also a certified drug and alcohol counselor gave medication to a co-worker at the addiction clinic where they both worked. The co-worker said he had a headache.

The US District Court for the Eastern District of Wisconsin upheld the facility's right to fire her, that is, the facility was not just trying to take away her retirement benefits as she claimed.

The co-worker had a lengthy personal history of addiction, but him having an addictive background was not a necessary factor for the facility to be able to fire her. She also claimed it was not the opiod propoxyphene but garden-variety ibuprofen she gave him, but that was also a non-issue in the court's judgment. Diversion of medication without a prescription is grossly inappropriate conduct. **Zocher-Burke v. Quality Addiction Management, Inc., 2007 WL 2821989 (E.D. Wisc., September 27, 2007).**

Patient's Fall: Court Endorses Nursing Expert's Opinion Re Substandard Hospital Nursing Care.

The patient was found alone on the floor in her hospital room with a femur fracture. She had been admitted two days earlier for pneumonia. She died twenty days after she fell.

On admission it was noted she had recently fallen and had difficulty ambulating without assistance. She was nevertheless allowed to ambulate ad lib with bathroom privileges.

On the night in question her nurse checked on her and found her alert and awake. The bed rails were up.

However, the patient's family's nursing expert was still able to find fault with the hospital's nursing care.

The patient's physician had written a progress note in the chart that the patient had complained the nurses were not answering her call light.

A registered nurse is an acceptable source of expert testimony in a civil case where the claim of malpractice relates to the nursing care provided to the patient in the hospital.

A nurse can testify as to appropriate measures to assess a patient's fall risk and prevent a patient from falling and that failure to take appropriate measures was what caused the fall.

COURT OF APPEALS OF TENNESSEE
September 21, 2007

Nurses ignoring or taking their time responding to the call light would tend to make the patient try to get up without assistance to go to the bathroom, the nursing expert said.

Further, the hospital's own policies required daily nursing assessment of every patient's fall risk. There was no nursing documentation that that was done on the day in question.

A current fall risk assessment, the family's nursing expert went on to say, would have pointed to the need for a bed alarm.

Bed alarms are now routinely being called for with 20/20 hindsight by plaintiffs' nursing expert witnesses in civil lawsuits filed after patients have fallen. **Vaughn v. Harton Reg. Med. Ctr., 2007 WL 2751800 (Tenn. App., September 21, 2007).**