LEGAL EAGLE EYE NEWSLETTER

November 2010 *For the Nursing Profession* Volume 18 Number 11

Narcotic Overdose: Brain Damaged Patient Gets Large Verdict For Nursing Negligence.

The patient's podiatrist wrote an order for pain medication, the order to accompany the patient upon discharge from the hospital to a rehab facility for an expected one-week stay following foot tendon surgery.

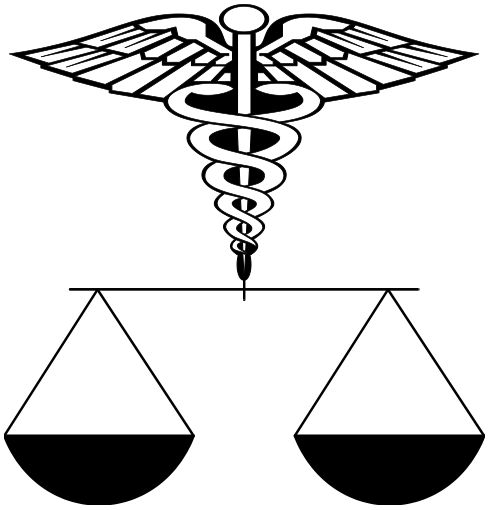
The podiatrist meant to order 50 mg of Demerol IM but instead wrote the order for 50 mg of morphine. He later admitted his mistake, that the dosage written was appropriate for Demerol but highly excessive for morphine.

The pharmacy in the rehab facility right away notified the nurse caring for the patient that 50 mg was an unusually high dose of morphine.

Verifying Questionable Drug Dosage Is a Nursing Responsibility

At this point the nurse was required by the rehab facility's policies and procedures to contact the treating physician to clarify the correct dosage before giving the medication. That was never done.

Instead, an individual in the rehab facility's administrative office was contacted for the go-ahead to administer the morphine. Nurses and other employees had to scour the facility looking for morphine to inject. The entire supply of morphine from the pharmacy and from emergency kits on the patient-care floors was pooled into one 30 mg dose that was given to the patient.



The podiatrist meant to order 50 mg of Demerol but instead wrote the order for 50 mg of morphine.

The nurses had to look everywhere just to find 30 mg of morphine to inject.

The nurse who gave it knew it was a mistake but gave it anyway and then did not check on the patient for signs of respiratory depression.

SUPERIOR COURT
ORANGE COUNTY, CALIFORNIA
August 19, 2010

The nurse who gave the medication admitted in court afterward that she realized the dosage was too high. On top of that the nurse did not monitor the patient's respiratory status after giving the narcotic and she never charted the dose before leaving for the day.

That night and early the next morning the nurses on duty did see signs of respiratory depression but they did not do anything about it or report it to the attending physician.

At 5:55 a.m. the patient was found unresponsive. He had pinpoint pupils and was barely breathing. An ambulance was called. The Glasgow Coma Scale assessment by the ambulance crew produced a score of only 4. Multiple doses of Narcan were given on the way to the hospital.

At the hospital it was discovered that the patient had suffered a mild heart attack and was in kidney failure due to lack of oxygen from narcotic-related respiratory depression.

The patient had to spend more than six months in a university teaching hospital undergoing rehab and still requires close supervision with his ADL's.

The jury in the Superior Court, Orange County, California awarded the patient $3,189,000. **Lefforge v. Covenant Care, 2010 WL 3918600 (Sup. Ct. Orange Co., California, August 19, 2010).**

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November 2010

New Subscriptions
See Page 3

Medicare/Medicaid: Hospice Care In Skilled Nursing, Long Term Care Facilities, New CMS Regulations.

On October 22, 2010 the US Centers for Medicare and Medicaid Services (CMS) announced proposed new regulations to ensure that long term care facilities, that is, skilled nursing facilities and nursing facilities, that arrange for hospice care through an agreement with one or more Medicare-certified hospice providers have in place a written agreement with the hospice provider that specifies their respective roles and responsibilities.

Under current regulations a long term care facility may choose to have a written agreement with one or more hospice providers to provide hospice care to a Medicare eligible resident who wishes to elect the hospice benefit.

However, if the facility chooses not to contract with a Medicare-certified hospice to provide hospice services for the resident who wishes to elect the benefit, the facility is responsible for assisting the resident in transferring to a facility that will arrange for the provision of such services.

CMS believes there is a lack of clear regulatory direction as to the responsibilities of providers caring for residents who receive hospice care from a Medicare-certified hospice provider, which could result in duplicative or missing services.

CMS believes this problem would be remedied by a regulatory requirement for a written agreement between the two types of entities when they are both involved in the care of a Medicare beneficiary. A written agreement would help ensure that required services are provided to beneficiaries and protect beneficiary health and safety, which could be endangered by a lack of coordination between hospice and long term care providers.

Such an agreement would ensure that care is coordinated by specifying what services each provider will provide. For instance, a long term care facility is considered a resident's home. An agreement between the providers would specify that the long term care facility must furnish room and board and meet personal care and nursing needs, while the hospice must provide services that are necessary for the care of the resident's terminal illness, such as counseling and palliation of pain.

CMS's proposed new regulations are not mandatory at this time. CMS is accepting public comments until December 21, 2010.

We have placed the full text of CMS's announcement on our website at http://www.nursinglaw.com/CMS102210.pdf.

The new regulations begin on page 9, Federal Register page 65290.

FEDERAL REGISTER October 22, 2010
Pages 65282 - 65291

FEDERAL REGISTER October 22, 2010
Pages 65282 - 65291

Fall Risk: Facility Responsible For Patient's Injuries.

The patient was a wheelchair-bound disabled person who had been involuntarily committed to a state psychiatric facility for treatment of mental illness.

During her stay in the facility she fell and was injured while using a non-handicap shower.

The Court of Claims of New York awarded the patient more than $400,000 in damages from the State for her injuries.

However, the settlement from her lawsuit against the State, while it still only existed on paper, became a personal asset which meant she was no longer medically indigent and was required to reimburse the State for her mental health treatment paid for by the State under Medicare.

The net benefit to the patient from her lawsuit was zero.

As a disabled individual the patient was entitled to reasonable accommodation in the form of a handicap shower to shower by herself, or a shower chair and the presence of an aide to assist her in showering.

COURT OF CLAIMS OF NEW YORK
January 29, 2010

The facility's director of nursing admitted in her court testimony that it was inappropriate for a disabled person to be expected to use a non-handicap shower unless she was at least given a shower chair and provided with an aide to assist her when showering.

The patient had been assessed as a high fall risk who required close assistance with activities of daily living. There was no fall-risk warning outside the door to her room to alert caregivers that she was a fall risk nor was a sticker to that effect placed on her medical chart. The aide assigned to care for the patient on the day in question apparently was not aware of her fall-risk status and of the need for close assistance. **Randone v. State of New York, 2010 WL 4079843 (N.Y. Ct. Cl., January 29, 2010).**

Medication Reaction: No Negligence.

The patient was admitted to the hospital following a suspected cardiac event. The physician ordered 3 mg of morphine.

Before giving the medication the nurse clarified with the patient from his description of the symptoms that a past episode was more likely an adverse reaction than an allergic reaction. The nurse gave the medication.

Later the patient claimed he started having problems with anxiety, depression and difficulty concentrating.

The jury in the District Court, Jefferson County, Texas found no negligence by the nurse and no liability by the hospital. **Corkran v. Christus Health, 2010 WL 4079867 (Dist Ct. Jefferson Co., Texas, September 21, 2010).**

Nurse Physically Restrained Patient: Court Throws Out Patient's Case Based On Mental-Health Immunity Law.

The patient went to the emergency room seeking treatment for cold symptoms and depression. She was accompanied by her mother and her son.

She shared with the physician the situations in her life which she believed were contributing to her depression including unemployment, homelessness, a verbally abusive husband and fear for her own safety.

The physician's impression from the way she was describing her dire situation was that she was thinking of harming herself. The patient, however, later denied having any such intention or expressing any such intention to the emergency room physician.

The physician told her to stay in the emergency department while arrangements were made for her to speak with a mental health professional.

Patient Tried to Leave the E.R. Restrained By a Hospital Nurse

The patient walked out about an hour after finishing with the physician, without seeing the mental health professional.

The emergency room physician told a nurse to follow her to the parking lot and stop her from leaving. The nurse told her not to leave and tried to grab her. They both fell to the ground and in the struggle the patient bit the nurse at least twice.

Mental healthcare professionals at an evaluation and treatment facility are immune from civil liability when performing their duties, including making the decision and detaining a person for evaluation, so long as their duties are performed in good faith and without gross negligence.

The professional staff at any public or private hospital may detain a person presenting with an imminent likelihood of serious harm as a result of a mental disorder for sufficient time to notify the county designated mental health professional of such person's condition.

This hospital is licensed for mental health treatment and evaluation. The patient's own statements led to a reasonable belief that she posed an imminent danger to herself.

COURT OF APPEALS OF WASHINGTON
October 11, 2010

With help from other hospital personnel the nurse was able to strap the patient to a gurney and return her to the emergency department.

The Court of Appeals of Washington dismissed the lawsuit the patient filed against the hospital alleging assault and battery, false imprisonment and malicious prosecution.

In the patient's lawsuit the emergency room nurse himself countersued the patient for assault and battery.

The Court pointed out that the patient went to this hospital, a licensed mental-health treatment facility, seeking treatment for depression. She reported that she had been depressed for over a year and was constantly crying and feared for her own safety. The physician came to a reasonable, good faith belief that the patient posed a danger to herself.

The hospital wanted to keep the patient pending an evaluation from a mental health professional to determine if further treatment was needed until the patient herself tried to thwart that plan.

The patient was unable to point to any evidence of bad faith or any gross departure from the standard of care by the emergency room physician, the nurse or any other hospital personnel.

The nurse was acting in a first-line mental health emergency. It was not relevant to the outcome of the patient's lawsuit that involuntary commitment proceedings had not yet been started and that the patient had not yet been committed for treatment. **Ross v. Peacehealth, 2010 WL 4008812 (Wash. App., October 11, 2010).**

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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

Patient's Fall: Nurse, Not Physician, Is Qualified To Testify As A Defense Expert Witness.

The seventy-seven year-old patient went in for a routine office visit with the doctor who had been her family practice physician for more than six years.

No Nursing Assessment Of Patient's Ability To Step On, Off Scale

The patient had risk factors for falling and these risk factors were all well documented in her office chart. The patient had had previous problems with vertigo and dizziness, was obese, had problems with her gait and was taking a number of prescription medications.

Nevertheless, after greeting her in the waiting room and leading her back to the scale to be weighed, the office nurse did not assess the patient's current condition by asking her how she was feeling and what it was that had brought her to the doctor's office that day.

As the patient stepped on the scale the nurse reportedly was holding a pen in one hand and the patient's chart in her other hand. That is, the nurse was not attempting to assist the patient to get on or off the scale.

As the patient stepped off the scale she fell and broke her hip in four places.

The patient and her husband sued a number of defendants for negligence. All of the defendants have been dropped from the case except for the management company who was the nurse's employer.

Nurse Accepted As Expert Witness

The nurse's employer's first line of defense was to argue that the patient's nursing and medical experts are not qualified to testify in a healthcare negligence lawsuit.

The Court of Appeals of Georgia reviewed the two experts' qualifications and ruled that the nurse, but not the physician were qualified to testify. The nursing expert herself has been regularly involved in nursing practice for the last five years in situations where patient-safety assessment is a vital nursing consideration, unlike the physician who has been practicing medicine. **Anderson v. Mountain Management Services, Inc., __ S.E. 2d __, 2010 WL 3991642 (Ga. App., October 13, 2010).**

The patient's nursing expert has worked in outpatient surgery, the recovery room and in the pain clinic at a local medical center.

Her nursing experience has involved evaluating patients to determine their needs and capabilities and assisting patients through the process of surgery.

Properly assisting a patient includes obtaining and reviewing the chart before greeting and interacting with the patient.

Assessing a patient's fall risk includes taking stock of the nurse's past knowledge of the patient, whether the patient is elderly, whether the patient uses assistive devices, how the patient is walking and how the patient is feels that day.

Evaluating patients' physical abilities to determine their safety needs is a fundamental nursing responsibility.

The patient's medical expert, on the other hand, is an internist with a background in family medicine. There is no indication he has practiced as a nurse or supervised or taught nurses in basic patient safety assessment.

COURT OF APPEALS OF GEORGIA
October 13, 2010

Fall: Nursing Assessment Was Appropriate, No Liability Found.

The seventy-four year-old patient was admitted for a twenty-three hour outpatient stay on the hospital's orthopedic floor after a fall at home where she lived in a two-story condo by herself.

On the morning she was going to be discharged home the patient told her nurse she had to go to the bathroom. The nurse placed a commode next to the bed, assisted her out of bed and on to the commode and told her to call when she was done so that he could assist her back into bed.

Out of respect for the patient's privacy the nurse then left the room.

The patient ended up on the floor with a fractured tibia that required surgical open reduction and internal fixation.

The hospital's medical expert, a geriatric specialist, testified the patient was stable and ready to be discharged home later on the morning that she fell.

It was appropriate for the patient's nurse to respect her privacy by leaving her on the commode alone with instructions to call for assistance when she was ready to get up.

SUPERIOR COURT
SANTA CLARA COUNTY, CALIFORNIA
July 2, 2010

The jury in the Superior Court, Santa Clara County, California found no negligence on the part of the patient's nurse.

Even with this patient's underlying problems which included rheumatoid arthritis and lower extremity weakness, the nurse accurately assessed her fall risk and safety awareness and took appropriate precautions by assisting her on to the commode and advising her to call for help when she was done. **Melrose v. Stanford Hosp., 2010 WL 4013861 (Sup. Ct. Santa Clara Co. California, July 2, 2010).**

Emergency Room: Assessment Ruled Adequate, No Liability Found.

The patient, himself a registered nurse, was taken to the hospital by ambulance after he was struck by a car and knocked unconscious as he was crossing the street.

The nurses and the physician in the E.R. did thorough exams.

There was no evidence of a skull fracture.

He was kept under observation for one and one half hours during which time here was no change in his condition that would indicate a closed head injury.

When a head CT was suggested the patient left against medical advice.

SUPERIOR COURT
LOS ANGELES COUNTY, CALIFORNIA
February 14, 2010

The patient left against medical advice around 4:00 a.m. after spending two hours in the E.R.

At 8:30 a.m. he was returned to the hospital by ambulance. He had a skull fracture and had been bleeding into his brain. He was pronounced dead a half hour later.

The jury in the Superior Court, Los Angeles County, California found no liability by the hospital. Experts in emergency medicine testified that a thorough nursing assessment and medical exam were done. The patient was not impaired by intoxication, so it was not inappropriate not to allow him to make his own decision to leave the hospital against medical advice after being advised to stay for a CT scan.

It was also plausible that the fatal injury did not actually occur until after he left the E.R. **Germany v. Cedars-Sinai Med. Ctr., 2010 WL 3625185 (Sup. Ct. Los Angeles Co., California, February 14, 2010).**

Labor & Delivery: Jury Declines To Fault Nurses.

The mother was admitted to the hospital with diagnoses preeclampsia and pregnancy-induced hypertension.

When her water broke two days later she was transferred from a meg/surg floor to the labor and delivery unit. She was given magnesium sulfate and Pitocin was started to aid her in her contractions.

Late that night the ob/gyn believed the patient was fully dilated. He told her to start pushing, then walked off the unit.

The labor and delivery nurses watched the monitor closely while the mother started pushing.

For a half hour late decelerations would appear in the fetal heart rate afterward each time the mother pushed.

The nurses had the mother continue pushing and did not call the ob/gyn.

CIRCUIT COURT
MILWAUKEE COUNTY, WISCONSIN
July 1, 2010

The jury in the Circuit Court, Milwaukee County, Wisconsin ruled the labor and delivery nurses were not at fault for allowing the mother to keep pushing for more than a half hour while late decelerations, which had not been there before, became apparent on the fetal monitor.

The ob/gyn had just visited the room, reviewed the monitor strips and personally examined the patient before he gave instructions to the nurses to have the mother start pushing.

The jury awarded more than $23,000,000 from the ob/gyn to pay for a lifetime of special care for the child who was born with cerebral palsy. The ob/gyn was faulted for leaving the labor and delivery unit during a critical period and then mismanaging the use of forceps in the delivery itself. **Birmingham v. Injured Patients Fund, 2010 WL 4065617 (Cir. Ct. Milwaukee Co., Wisconsin, July 1, 2010).**

Discrimination: Discipline Handed Out Only To Minority Aide.

The facility agreed to reinstate an African-American CNA and to pay him a $100,000 settlement to resolve his civil rights lawsuit filed in the US District Court for the Northern District of California.

An African-American CNA was physically accosted on the job by his acting supervisor, a Caucasian psychiatric technician.

The CNA was suspended and steps were taken to terminate him. Nothing was done to the psych tech.

UNITED STATES DISTRICT COURT
CALIFORNIA
April 6, 2010

Reportedly the altercation left certain of his co-workers afraid of him and feeling physically threatened.

The process was started to terminate the CNA, a civil service employee with vested rights, on the grounds that it was not assured that he would adhere to the facility's policy against violence in the workplace and that he was unwilling to take responsibility for his own behavior which contributed to the negative interaction with the psychiatric technician.

The minority CNA did refuse to participate in anger management and conflict resolution training as was recommended and declined to enter into a written agreement with the other party concerning their future relationship working together on the job and to sign a written acknowledgment of the facility's workplace violence and harassment policies.

The upshot of the case was the lack of any explanation why the minority employee alone was held responsible for an incident in which both parties seemed at least equally at fault, if in fact the other party was not actually more to blame. **Harris v. City and County of San Francisco, 2010 WL 4013858 (N.D. Cal., April 6, 2010).**

Emergency Room: Hospital's Own Rules Were Not Followed, Jury Verdict Against Hospital.

The patient died at home from a myocardial infarction two hours after spending twenty-seven minutes in the E.R. and then being sent home. The Supreme Court of Tennessee ruled the jury was correct to hold the hospital responsible.

Possible Cardiac Symptoms
Left Arm Sprain Diagnosed
Patient Sent Home

The patient had spent the morning working in his garden and using an ax and other hand tools to clear and clean up his yard. Around noon he stopped working and went in the house to soak and apply ice to his left arm which was hurting. The pain did not subside and he began to feel worse so his wife drove him to the emergency room.

On arrival in the E.R. the patient was seen by a paramedic. The patient explained that his left arm and wrist hurt. His wife added that he was sick to his stomach. The paramedic took vital signs, BP 130/70, pulse 100 and respirations 20. A nurse practitioner then saw the patient. Her diagnosis was left arm sprain from overuse. After conferring with the E.R. physician the nurse practitioner sent the patient home with instructions to take over-the-counter pain medication and apply ice to his arm.

No cardiac workup was done. He left the hospital less than thirty minutes after he arrived.

Two hours later the patient collapsed at home and was taken back to the hospital by ambulance where he was pronounced dead from a myocardial infarction.

The widow filed a lawsuit alleging that the hospital was negligent because her husband was not triaged by a registered nurse and was never actually seen or examined by a physician.

If the appropriate professionals had seen the patient they would have known to explore his medical history more fully, the jury believed. He was obese and a heavy smoker with high cholesterol and a family history of heart disease. Cardiac involvement should have been ruled out. **Barkes v. River Park Hosp., __ S.W. 3d __, 2010 WL 4117151 (Tenn., October 20, 2010).**

The family's expert witness holds a PhD in hospital administration.

The standard of care for the emergency department calls for a registered nurse to triage the patient and for a physician actually to see the patient before the patient is allowed to go home.

The hospital's own policies and procedures, as written, are in accord with the standard of care, but there was an apparent problem with those policies and procedures being successfully communicated to staff members in the emergency department.

The emergency department nurse practitioner was unaware of the hospital's policy requiring every patient presenting in the emergency department to be seen by a physician.

The physician testified she would have more closely evaluated the patient for cardiac involvement if she had known the patient was a heavy smoker and obese and had a family history of cardiac problems, information a physician would routinely obtain from a patient under the circumstances, if she had actually seen him.

SUPREME COURT OF TENNESSEE
October 20, 2010

Emergency Room: Patient Disagreed With Treatment Plan, Court Sees No Liability.

The patient had to register as a self-pay patient because he had used up all of his Medicaid medical coupons.

The E.R. nurse practitioner refused the patient's request for the antibiotic of his choice because he did not show any signs or symptoms of a bacterial infection.

Instead, after consulting with the E.R. physician the nurse practitioner did offer to prescribe a non-narcotic analgesic for the patient.

A verbal confrontation erupted. The patient was told he would have to leave the E.R. or the police would be called.

The patient sued the hospital claiming he was denied necessary emergency treatment based on his lack of medical insurance and inability to pay.

The nurse practitioner in the E.R. would not prescribe the antibiotic that the patient requested because the patient was not running a fever and had no other signs or symptoms of a bacterial infection.

UNITED STATES DISTRICT COURT
MISSISSIPPI
October 4, 2010

The US District Court for the Southern District of Mississippi ruled the nurse practitioner did not violate the US Emergency Medical Treatment and Active Labor Act (EMTALA).

The Act requires every emergency room patient to be screened and treated the same as every other emergency patient with the same signs and symptoms, which was done in this case.

The Act does not give the patient permission to dictate a plan of care which is not appropriate, whether or not the patient has medical insurance or private funds. **Buras v. Highland Community Hosp., 2010 WL 3937631 (S.D. Miss., October 4, 2010).**

Skin Care: Nursing Documentation Lacking, Settlement Paid.

During her first two months in the nursing home the patient developed multiple State IV decubitus lesions on her sacrum, thighs, buttocks and heels.

During the patient's first two months there were no records of the patient being turned and repositioned.

Nevertheless, the patient's chart did document the emergence of serious wounds on her body.

Weekly skin assessments during the two first weeks showed a Stage II lesion which progressed to Stage IV two weeks later.

Then the skin assessments stopped.

Lack of documentation of assessment and turning of the patient means that it was not done.

NEW YORK SUPREME COURT
BRONX COUNTY
November 12, 2009

The lawyers representing the patient's probate estate were prepared make their case by pointing to the lack of documentation of turning and repositioning and consistent assessments, while it was documented that serious problems with skin integrity were emerging and progressing, according to the same medical chart.

The lawyers were also prepared to point to the nursing home's operating manual policies and procedures as the standard of care which spelled out measures which were never undertaken for this patient.

The lawsuit filed in the Supreme Court, Bronx County, New York settled for $300,000. **Garcia v. Jewish Home, 2009 WL 6966811 (Sup. Ct. Bronx Co., New York, November 12, 2009).**

Skin Care: Large Jury Verdict Faults Nursing Care.

The fifty year-old patient was admitted to a rehab facility after sustaining a gunshot wound that left him paralyzed from the waist down.

During his ten days in the facility the patient was left lying on his back most of the time, a fact that was borne out by his medical chart.

He developed a saucer-sized Stage IV decubitus ulcer on his lower back which required three debridements, a wound-flap procedure and a colostomy.

Nurses Admitted They Failed to Turn the Patient Every Two Hours

Six nurses who cared for the patient during his stay were named as defendants in the lawsuit along with the corporate parent that owned the rehab facility.

Each of the nurses reportedly admitted in her pre-trial deposition testimony that the accepted standard of care was to turn and reposition this patient every two hours and that it was not done with this patient.

The nurses argued in their defense that the patient's long list of other medical problems made it very likely he would have developed serious problems with skin integrity even if he had been turned and repositioned according to accepted nursing standards. Lawyers for the rehab facility also brought in an internist and a nurse as expert witnesses who expressed basically the same opinion.

The patient died before the case went to court. His widow continued the lawsuit on behalf of his probate estate. Her lawyers admitted for purposes of the lawsuit that his care in the rehab facility did not cause or contribute to his death.

Nevertheless the ordeal he endured with his skin-integrity issues, according to the physician and the nurse the widow's lawyers brought in as experts, was clearly the fault of the patient's nurses.

The jury in the Court of Common Pleas, Richland County, South Carolina awarded damages of $12,306,625 against the nurses individually and against their employer. **Sulton v. HealthSouth Rehab, 2010 WL 4111517 (Ct. Comm. Pl. Richland Co., South Carolina, July 30, 2010).**

Wound Care: Nurse Drops Dressing, Jury Awards Damages.

The patient was transferred from the hospital to a rehab facility several days after hip replacement surgery.

His care plan called for his surgical wound to be cleansed and the dressing changed daily by the rehab nurses.

One week after surgery a nurse was changing the dressing on his surgical wound. The nurse reportedly dropped the dressing on the floor, then picked it up and reapplied it to his wound.

The nurse removed the dressing from the patient's surgical wound, dropped it on the floor, picked it up and reapplied it.

The patient complained to another nurse the next morning and she changed the dressing.

DISTRICT COURT
SEDGWICK COUNTY, KANSAS
October 13, 2009

The patient was discharged home the next day. Eight days later, however, he had to be readmitted to the hospital where he had had his surgery.

An *E. coli* infection was diagnosed in the wound. At the hospital the wound was irrigated and debrided. The hip prosthesis had to be removed and re-implanted some months later.

The patient's lawsuit filed in the District Court, Sedgwick County, Kansas alleged the nurse's care fell below the standard of care. The lawsuit also alleged that the rehab facility itself was negligent for failing to train its nurses in wound care and infection control standards and for failing to select and evaluate its nurses so that a competent nurse would be assigned to his care. The jury awarded the patient $437,293 from the rehab facility. **Kerns v. HCA Wesley Rehab, 2009 WL 6923576 (Dist. Ct. Sedgwick Co., Kansas, October 13, 2009).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Patient Death: Hospital Held Liable For Fraud In Obtaining Consent To Perform Autopsy.

The sixty-one year-old patient entered the hospital for treatment of kidney stones.

Three days into his hospital stay he was found dead ninety minutes after a hospital nurse administered Demerol and Phenergan which had been ordered in combination for pain control and sedation.

The patient's widow's lawsuit alleged, among other things, that the nurse was negligent for administering medications which can cause respiratory depression and then failing to check on the patient for ninety minutes, an excessive delay under the circumstances.

Any patient's respiratory status must be monitored after receiving narcotic medications and this patient in particular had impaired liver function which could have hindered effective clearance of the medication from his system.

However, the jury in the District Court, Harris County, Texas was not convinced there was any violation of the standard of care by the patient's nurse.

The jury nevertheless awarded the widow $2,000,000 in damages from the hospital for what happened shortly after the patient died.

Representatives from the hospital persuaded the widow to authorize an autopsy by a pathologist chosen and paid for by the hospital. The widow reportedly was told that the county medical examiner would not take the case and that the hospital was trying to spare her from having to hire a private pathologist which would be prohibitively expensive for her.

Urine and blood samples taken from the corpse by the hospital's pathologist were disposed of after the autopsy. The patient's heart was kept for further study. The corpse was released to the family for burial without the heart and without the family even knowing that the heart was missing.

Spoliation of the Evidence
Interference With the Right of Internment

Depriving the patient or the patient's family of the evidence of a possible malpractice claim, molesting the patient's remains or depriving the patient's next of kin of the ability to conduct a proper funeral and burial are grounds for legal liability separate and apart from professional malpractice. **Carswell v. Christus Health, 2010 WL 4079656 (Dist. Ct. Harris Co., Texas, September 13, 2010).**

Labor & Delivery: Nurses Did Not Notify Ob/Gyn Of Changes In Patient's Hemodynamic Status.

The patient was admitted to the hospital to induce labor at more than forty-one weeks.

After several hours of very slow progress in labor the ob/gyn decided to do a cesarean. The patient was transferred afterward to the post anesthesia care unit where the same labor and delivery nurse who had been with her during labor took over her care.

200 ml of blood tinged urine and some dark red blood showed up in the Foley bag. Her BP before surgery had been 118/74 but dropped to 98/52. Her heart rate had been 84 and rose to 100.

She was transferred from post anesthesia recovery to a med/surg floor during the night. On her first assessment the med/surg nurse got a BP of 98/52 and pulse 102. An hour later her BP was 75/50 and pulse 111.

The standard of care requires nurses caring for a patient after a cesarean to be aware of the risk and to be vigilant for signs of internal bleeding.

Changes in this patient's blood pressure and heart rate were consistent with post partum hemorrhage.

Critical data must be communicated to the attending physician while there still is time to intervene and correct the problem.

COURT OF APPEALS OF TEXAS
October 21, 2010

Ten minutes later her BP dropped to 68/48. The med/surg nurse called the ob/gyn. A surgical team was assembled and started an exploratory laparotomy two hours after the nurse's call.

Four liters of blood from uterine bleeding were found in the patient's abdominal cavity.

The patient was stable when she left the operating room for the ICU, but only thirty minutes later went into full cardiac arrest. She was pronounced dead early that morning.

The family's expert witness's preliminary report pointed to death from exsanguination traceable to nursing negligence. The Court of Appeals of Texas ruled the expert's report was a sufficient evidentiary basis for the case. **Doctors Hosp. v. Hernandez, __ S.W. 3d __, 2010 WL 4121678 (Tex. App., October 21, 2010).**