LEGAL EAGLE EYE NEWSLETTER

November 2011 *For the Nursing Profession* Volume 19 Number 11

E.R.: Nurses Ruled Not Liable, Patient Died From MI Only Hours After Discharge Home.

A $1.3 million jury verdict has been overturned which we reported in December 2010: *Emergency Room: Nurses Blamed For Patient's Death From MI After Discharge Home,* Legal Eagle Eye Newsletter for the Nursing Profession, (18)12, Dec. '10, p. 6.

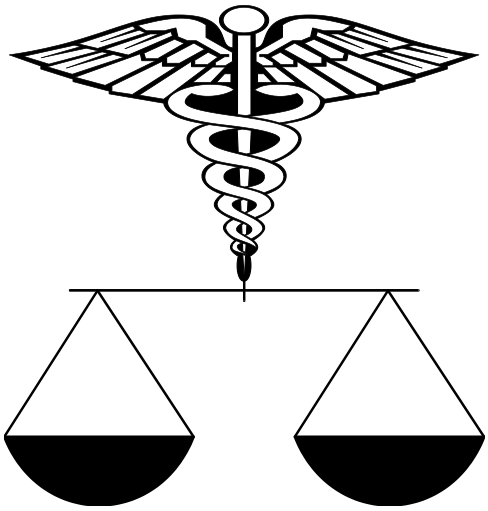
The Court of Appeals of Texas was highly critical of the nursing care the patient received in the emergency room but nevertheless found no liability in the family's lawsuit against the hospital because the nursing care, although negligent, did not rise to the level of willful or wanton negligence, a wrinkle of Texas's medical malpractice law.

The patient was triaged by a nurse within minutes after arriving in the E.R. and telling the desk clerk her reason for coming in was chest pain.

She was not short of breath. She told the triage nurse her pain level was 8/10. Her heart rate was 97, BP 186/96 and O_2 sat 97%.

The nurse obtained a history of smoking, hypertension and a CVA. The patient's meds were Glucophage and Avandia for diabetes, Norvasc for angina and Accupril for hypertension but she had not been taking the last three.

The nurse erroneously classified the patient as level three, somewhat urgent but not presenting with life-threatening problems.



The hospital's E.R. nurses did not follow the hospital's procedures for the assessment and treatment of chest pain and by not doing so they deviated from the accepted standard of care.

However, the nurses' errors and omissions, although negligent, did not rise to the level of willful or wanton negligence.

COURT OF APPEALS OF TEXAS
October 13, 2011

The Court said this patient should have been classified as level one, presenting with a potentially life-threatening condition.

The initial nursing triage is a critical step in the emergency-care process, the family's nursing experts said. The initial nursing assessment sets the tone for how the patient's case will be handled by all of the caregivers who will interact with the patient.

Minimizing this patient's level of acuity was a significant factor in her simply being sent home by the E.R. physician with a prescription for lisinopril and a recommendation to follow up with her cardiologist rather than being sent to the catheterization lab or worked up for coronary artery bypass.

It is a nursing responsibility to probe into the location and severity of the pain reported by a patient who comes to the E.R. for chest pain, especially one with a history of risk factors.

A patient with a cardiac history and current unstable angina can display normal vital signs and EKG as this patient apparently did at the time of her discharge home from the E.R. That does not necessarily mean that the patient is not in dire need of urgent care, the Court pointed out. **Christus Health v. Licatino, __ S.W. 3d __, 2011 WL 4841082 (Tex. App., October 13, 2011).**

www.nursinglaw.com/nov11stp3.pdf

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New Subscriptions
See Page 3

Medicare/Medicaid: New Regulations Proposed.

Sec. 482.13 Condition of participation: Patient's Rights.

* * * * *

(g) * * *

(1) With the exception of deaths described under paragraph (g)(2) of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

(2) When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must report to CMS by recording in a log or other system, the following information:

(i) Any death that occurs while a patient is in such restraints; and

(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

(3) For deaths described in paragraphs (g)(1) and (g)(2) of this section, staff must document in the patient's medical record the date and time the death was reported to CMS.

(4) For deaths described in paragraph (g)(2) of this section, entries into the log or other system must be documented as follows:

(i) Each entry must be made not later than seven days after the date of death of the patient;

On October 24, 2011 the US Centers for Medicare and Medicaid Services published proposed new regulations for hospitals.

The proposed new regulations are not mandatory at this time. CMS is accepting public comments until December 23, 2011.

Excerpts are reproduced on this page which we believe are those most relevant to nursing practice.

The full text of CMS's announcement is available at http://www.nursinglaw.com/CMS102411.pdf

FEDERAL REGISTER October 24, 2011
Pages 65891-65908

(ii) Each entry must document the patient's name, date of birth, date of death, attending physician's name, medical record number, and primary diagnosis(es); and

(iii) The information must be made available in either written or electronic form to CMS immediately upon request.

Sec. 482.23 Condition of participation: Nursing Services.

* * * * *

(b) * * *

(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.

* * * * *

(c) Standard: Preparation and administration of drugs.

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(i) If verbal orders are used, they are to be used infrequently.

(ii) When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedures consistent with Federal and State law.

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(5) There must be a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.

(6) The hospital may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient's own medications brought into the hospital, as defined and specified in the hospital's policies and procedures.

(i) If the hospital allows a patient to self-administer specific hospital-issued medications, then the hospital must have policies and procedures in place to:

(A) Assure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration;

(B) Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s);

(C) Instruct the patient (or the patient's caregiver/support person where appropriate) in the safe and accurate administration of the specified medication(s);

(D) Ensure the security of the medication(s) for each patient; and

(E) Document the administration of each medication in the patient's medical record.

(ii) If the hospital allows a patient to self-administer his or her own specific medications brought into the hospital, then the hospital must have policies and procedures in place to:

(A) Assure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration of medications the patient brought into the hospital;

(B) Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s), and also determine if the patient (or the patient's caregiver/support person where appropriate) needs instruction in the safe and accurate administration of the specified medication(s);

(C) Identify the specified medication(s) and visually evaluate the medication(s) for integrity;

(D) Ensure the security of the medication(s) for each patient; and

(E) Document the administration of each medication in the patient's medical record.

Discrimination: Patient Was Discharged Due To HIV+ Status, Damages And Penalty Imposed.

The patient was thirty-six years old and suffered from bipolar disorder and schizophrenia. She was diagnosed with HIV in 1998.

She resided for a time in a group home run by a human services agency. The program at the group home was designed to assist individuals with disabilities to move toward greater independence by providing assistance with transportation and job searches as well as room and board.

While living in the group home the patient began to have a major problem with urinary incontinence.

Staff tried to put her on a training program and had her wear an adult diaper, but it became clear that the resources at the group home were not adequate.

A decision was made to seek a placement in a personal-care facility where her needs could be better met.

The group home contacted a personal-care facility, had the patient go for a tour of the premises and an interview and helped her with her application paperwork. All the arrangements were set to go.

However, during the whole process the group home never mentioned the extent of the patient's problem with urinary incontinence. Nor did they mention her HIV status, that being confidential information that could not be divulged.

It is a discriminatory practice for a nursing facility to refuse accommodation on the basis of a number of factors, including disability.

HIV-positive status is a disability for purposes of anti-discrimination law.

The patient's physician assured the owner of the facility that the staff had no reason to be fearful of HIV infection from the patient's urine-soaked clothes or soiled bed linens.

Routine universal precautions, which had been in place at the facility for years, were all that was necessary to ensure the safety of the facility's staff.

Personal-care staff being afraid of an HIV+ patient and threatening to walk off the job is not a valid reason to discriminate against a disabled person in violation of the law.

COMMONWEALTH COURT
OF PENNSYLVANIA
October 20, 2011

Problems began within moments of the patient checking into the personal-care home. An aide who helped her unpack noticed that her clothes were soaked with urine and smelled very bad. Her clothes were washed and a toileting plan was included in her chart that she be taken to the bathroom on a q 2 hour schedule.

When her medications were checked in by a nursing assistant it was found that she was taking Valtrex for shingles and further investigation revealed that her shingles were related to HIV infection.

The owner phoned the physician to clarify what needed to be done to protect the staff from HIV. Nothing special was necessary above and beyond routine universal precautions. The owner was nevertheless very upset that the patient's HIV status had not been made known.

The patient was sent home with her sister the next day after she soiled her bed during the night. The sister realized she could not care for her at home and took her to a psychiatric hospital where she stayed for three months before being discharged to another nursing facility.

The Commonwealth Court of Pennsylvania agreed with the state Human Relations Commission that the personal-care home was guilty of HIV discrimination for sending the patient home with her sister when the facility was fully capable of caring for her with her disability. $50,000 was awarded to the patient from the facility and the facility was fined an additional $5,000. **Canal Side v. Human Relations Comm., __ A. 3d __, 2011 WL 4986670 (Pa. Comwlth., October 20, 2011).**

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Disability Discrimination: Nurse Not Able To Fulfill Essential Job Functions, Lawsuit Dismissed.

More than two years after being promoted to a management-level position a registered nurse was demoted back to a staff nurse position following complaints over her job performance.

In an effort to get her management position back, the nurse got documentation from her physician that she was not able to perform the duties of a staff nurse because of an old wrist injury.

However, because there was now a record of her being unable to fulfill the essential functions of the job description of staff nurse she was involuntarily put on medical leave for a year until she was finally able to retire from her long-term employment with the hospital system.

Not Able to Fulfill Essential Functions Not a Qualified Individual With a Disability

The nurse was precluded from direct patient care by her own doctor's assessment as well the hospital's examining orthopedist's that she could not lift, restrain or transport patients herself, being unable to lift more than ten pounds or push or pull a gurney or a wheelchair.

Nor was she able to sit or stand for more than twenty minutes at a time.

The court itself does not define the essential functions of a staff nurse's job in making the decision whether a nurse claiming disability is nevertheless able.

The court looks instead to the way the essential functions of the position are defined by the facility and compares that to the objective physical performance data that the physicians have been able to come up with who have either treated or examined the individual in question.

Promotion Is Not Reasonable Accommodation

The Court ruled that promotion to a sedentary management position, asked for not on the basis of merit but instead only as reasonable accommodation to a disability, is inherently unreasonable and the nurse in this case was asking too much in her disability discrimination claim to expect such unduly favorable treatment. **Davis v. New York Health & Hosp. Corp., 2011 WL 4526135 (S.D.N.Y., September 29, 2011).**

The Americans With Disabilities Act outlaws discrimination against an otherwise qualified individual with a disability.

A disabled person is not otherwise qualified unless he or she, with or without reasonable accommodation, is able to perform the essential functions of the position in question.

In defining what functions are essential for a particular position, the employer's judgment carries considerable weight with the courts.

The hospital system in this case had functional job descriptions for the responsibilities of a head nurse and a staff nurse which included direct patient care both individually and as members of a team, including being able to assist in crisis and emergency situations including codes and CPR and transfers and transport of patients.

The nurse pointed to other nurses whose problems did receive accommodation, one who limped, one with back problems and one with hand injuries. However, it is not clear that these other nurses were valid bases for comparison.

UNITED STATES DISTRICT COURT
NEW YORK
September 29, 2011

Patient Abuse: Aide's Lawsuit For Defamation Dismissed.

A nursing-home nurses aide was reported to her supervisor by a co-worker for alleged abuse of a patient.

The supervisor reported the aide to local law enforcement. The co-worker, the supervisor and others gave statements to law enforcement officials as part of the resulting criminal investigation.

Nursing employees are required by law to report abuse of vulnerable persons to their supervisors.

Nursing facilities are required to report abuse to law enforcement.

For reporting abuse, employees and facilities have legal immunity from civil defamation lawsuits.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
October 11, 2011

The US Court of Appeals for the Fourth Circuit did not have to consider whether the abuse allegations were true to dismiss the civil defamation lawsuit that was filed against the nursing facility, the supervisor and the co-worker by the aide.

In general, a person can file a civil lawsuit for defamation against someone who harms the person by making a false statement about them to a third person.

However, abuse reporting is a special situation. Caregivers, their supervisors and their employers are required by law to report suspected abuse of vulnerable individuals under their care by care-giving co-workers, family members and others.

For making these required reports in good faith, caregivers are protected from civil lawsuits. The legal issue is not whether their statements turn out not to be actually true. The only question is whether they acted in good faith. **Blankson-Arkoful v. Sunrise Senior Living, 2011 WL 4793215 (4th Cir., October 11, 2011).**

Dystonia: Nurse Not Disabled, No Right To Sue.

An ICU nurse suffered from dystonia for which her physician surgically implanted a brain stimulation device in her head as treatment for chronic pain.

That meant she was not able to work near MRI equipment but was otherwise cleared to return to intensive-care nursing.

When she returned to work she brought with her a note from her physician recommending that she work only in the cardio-thoracic intensive care unit.

The hospital, however, insisted that as an intensive-care float nurse she had to work in other intensive-care settings, which she refused to do. She left and went to work in the ICU at another hospital.

The nurse's only absolute medical restriction was that she could not work around MRI equipment because she has a surgically-implanted deep brain stimulation device in her head.

None of the intensive-care units in this hospital are close to MRI equipment.

UNITED STATES DISTRICT COURT
NEW YORK
September 26, 2011

The US District Court for the Southern District of New York dismissed the disability-discrimination lawsuit the nurse filed against her former employer.

The nurse was not disabled. Inability to work in a particular location while being able to work in the same occupation in other locations is not a disability for purposes of disability-discrimination law.

Secondly, even if the employee has a legitimate disability, a note from a physician recommending the employee work only in the one particular setting that the employee prefers, and not in other settings which do not violate the employee's medical restrictions, is not grounds to expect reasonable accommodation. **Serdans v. Presbyterian Hosp., 2011 WL 4443956 (S.D.N.Y., September 26, 2011).**

Place-Related Asthma: Court Dismisses Nurse's Disability Discrimination Lawsuit.

The nurse's asthmatic symptoms were triggered only in the main hospital building and nowhere else on the hospital's campus or anywhere else off the hospital's premises.

There was a major impairment when her symptoms were triggered.

Nevertheless, this condition is not a disability as contemplated by the Americans With Disabilities Act.

The nurse's symptoms were transient. Her symptoms lasted no longer than the time spent inside the main hospital building plus a brief period of recovery after leaving the building.

The nurse experienced her symptoms only at this particular workplace and not in any other workplaces or in public places.

The nurse's asthma does not affect any of her daily activities or limit her breathing in any manner or location outside this hospital's main hospital facility.

The nurse stated in her lawsuit that she is not impaired when she is in other facilities and she now works in another healthcare facility without any difficulty related to her asthma.

UNITED STATES DISTRICT COURT
WEST VIRGINIA
September 23, 2011

A nurse quit her job as a hospital staff nurse after her physician determined that her asthma symptoms were triggered by her being in the main hospital building of the hospital facility where she worked and not in other places on the campus or off the hospital's premises.

Nurse Did Not Have a Disability Lawsuit Dismissed

The US District Court for the Southern District of West Virginia pointed out in passing that it was not at all clear that the nurse ever requested reasonable accommodation before quitting her job.

The Court was able to leave that issue aside and still reach a decision in the hospital's favor on the basis that the nurse did not have a disability as contemplated by the Americans With Disability Act.

For legal purposes, if the individual does not have a disability it is not relevant whether the person asked for reasonable accommodation or was given reasonable accommodation by the employer. The court will rule against the individual's right to sue for disability discrimination if the individual did not have a disability.

In general terms, a disability is a physical or mental condition which substantially limits the person's ability to perform a major life activity that a person in the general population is able to perform.

In defining the term disability, the courts have not gone so far as to include conditions which cause symptoms to flare up only at work but not off the job.

Specifically dealing with asthma, the courts have said that an asthmatic condition is not a disability if it only limits the individual from one particular job or a narrow category of jobs, without affecting the individual in other related employment or places of employment or off the job.

An asthmatic condition is an employment disability if it can be triggered by a wide variety of substances on and off the job and thus substantially limits the major life activity of breathing by requiring the individual to avoid a wide variety of everyday activities. **Adkins v. Cabell Huntington Hosp., 2011 WL 4458759 (S.D.W.Va., September 23, 2011).**

Controlled Substances: Nurse Guilty Of Medication Errors, Discrimination Suit Dismissed.

A male nurse of Russian ancestry was terminated from his position in the ICU after a series of errors in the administration and documentation of narcotics.

One of the incidents involved IV bags hung during the night containing fentanyl which emptied much more rapidly than the ordered drip rate, without evidence of leakage or patient overdose, leading to suspicion the nurse injected himself. The rest were basically failures to adhere strictly to rules for correct documentation.

Russian Ancestry
National-Origin Discrimination

The US District Court for the District of Maryland stated at the outset that a Caucasian male nurse of Russian ancestry would be considered a minority for purposes of anti-discrimination law, but that is only one element of a discrimination case.

Documentation Errors
Legitimate Non-Discriminatory
Reason for Termination

The Court said that the nurse demonstrated what it called a pervasive pattern of documentation errors involving controlled substances. Narcotics diversion could not be proven, but the nurse's errors and omissions nevertheless jeopardized the integrity of the facility's procedures, threatened its accreditation and put the health and safety of its patients at risk.

Other Nurses
Were Not Valid Basis for Comparison

Even if an employee has been proven guilty of misconduct that justifies termination or other severe disciplinary measures, the employee can still sue for discrimination if other non-minority employees were not disciplined as severely for basically the same offense or offenses.

Another nurse was verbally warned, not fired, for a series of medication errors, but she had not yet completed her competency training like the nurse in this case had. Still another nurse was also counseled rather than fired, but he violated several different facility policies only once each before accepting correction, not the same rules over and over again like the nurse in this case. **Volochayev v. Sebelius, 2011 WL 4747898 (D.Md., October 5, 2011).**

The nurse cannot raise the issue of discrimination as a defense to his termination.

The facility is correct that the nurse in question failed to prove that he was performing his duties at a level that met the facility's legitimate expectations at the time of his termination.

The facility had legitimate, non-discriminatory reasons for firing him, despite the fact he was a minority.

The nurse had pervasive problems with documentation of his narcotic meds.

The nurse was aware of the procedures in question and the institutional risks raised by his conduct with regard to the facility's accreditation.

The nurse is not correct to argue there is any relevance to the fact that his conduct was never proven to have injured a patient.

Other nurses were counseled for their documentation issues rather than terminated.

However, their situations were not the same. One, unlike him, was basically still in training. Another nurse violated any given rule only once before accepting correction.

UNITED STATES DISTRICT COURT
MARYLAND
October 5, 2011

Arbitration: Agreement Is Valid, Family's Case Will Not Go Before A Jury.

After the patient passed away the family sued the nursing facility where she resided for ten months before they had her transferred elsewhere three months before she died. The cause of death was listed as end-stage Alzheimer's disease.

She was eighty-nine years-old, immobile and bedridden, requiring frequent repositioning by facility staff. She suffered from skin tears and bedsores, allegedly due to care planning which was inadequate and understaffing which was a factor in the facility being able to meet her needs.

Facility Countered Family's Lawsuit
By Asking for Arbitration

The facility's first response to the lawsuit the family filed in the local county Superior Court was to ask the Superior Court to dismiss the civil lawsuit in favor of arbitration based on the arbitration agreement signed by the resident the day she entered the facility.

The Court of Appeal of California agreed with the nursing facility and with the Superior Court that the family's lawsuit alleging malpractice and wrongful death belonged in arbitration.

No Unfairness Found

The arbitration agreement informed the resident that if she signed it she would give up the right to have disputes with the nursing facility heard by a judge or jury, even if her family sued *post mortem*.

No one tried to take advantage of the resident by forcing her to sign something she or the family did not understand or want to sign. The arbitration agreement was not required as a pre-condition for admission and even if the resident did sign it she still had thirty days to revoke her signature and remain in the facility.

No evidence was given to the Court that the resident lacked mental capacity when she entered the nursing facility. Whether that was true was not the point. When a contract is signed mental capacity is presumed. Lack of mental capacity has to be proven. **Negrete v. Grancare, 2011 WL 4906602 (Cal. App., October 11, 2011).**

Sponge Count Off: Court Awards Patient Damages.

The twenty-eight year-old patient underwent a laparoscopic lap-band procedure intended for weight control.

Afterward there was unusual drainage at the site of the incision for the lap-band port. A CT scan showed haziness at the wound site which was interpreted as a possible retained lap sponge. The patient came back seventeen days after the original surgery for an exploratory procedure during which a crumpled lap sponge was removed from just under the skin near the incision for the lap-band port.

All three required sponge counts were accurate and complete according to the charting done by the circulating nurse and the surgical technician.

However, the third count must have been wrong, because there was a crumpled lap sponge found just under the skin where the surgeon had inserted the port for the lap band.

COURT OF APPEAL OF LOUISIANA
October 5, 2011

The Court of Appeal of Louisiana upheld a judgment in the patient's favor splitting fault 50/50 between the surgeon and the hospital.

The circulating nurse and surgical tech had no actual recollection of this particular case when they testified in court.

In their testimony the circulating nurse and the surgical technician outlined in detail the hospital's three-step procedure for sponge and instrument counts, all of which were ostensibly correct in this case according to their documentation.

Notwithstanding their complete understanding of procedures and their ostensibly correct chart record, a lap sponge was in fact left inside this patient and they were partly responsible, the Court ruled. **Davis v. Women and Children's, __ So. 3d __, 2011 WL 4579137 (La. App., October 5, 2011).**

Patient Fall: Nurse Did Not Turn Bed Alarm Back On.

The eighty-six year-old patient was admitted to the hospital after she fell at home.

Due to her classification as a high fall risk the orders were to raise the side rails on both sides of the patient's bed.

In addition, the patient had an alarm which activated a warning light if and when the patient made contact with the floor near the bed.

The patient was found on the floor of her room at 5:30 a.m. with a fractured right femur. She had apparently injured herself climbing over the bed rails out of bed or by falling down soon after she got out of bed.

The chart contained notations of the night nurse's neuro checks on the patient before midnight and again at 4:00 a.m.

The patient's nursing experts believed the night nurse or one of the aides must have turned off the bed alarm when checking on the patient and neglected to turn it back on.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
October 18, 2011

The Superior Court of New Jersey ruled the family's lawyers could not add the nursing personnel individually as defendants because the family's lawyers waited until after the statute of limitations had expired. A lawsuit was filed in time, but only against the hospital itself, seeking damages for the fracture and claiming that the fall caused the onset of her dementia.

The patient's lawyers obtained a copy of her chart even before they sued the hospital. The chart identified the night nurse and the aides involved in her care. Their documentation tended to allow for the theory that the bed alarm was not turned on again after a nighttime neuro check. **Ruday v. Shore Mem. Hosp., 2011 WL 4916411 (N.J. App., October 18, 2011).**

Quad Care: Nurses Admit They Falsified Ventilator Care Flow Sheets.

The patient was an eleven year-old who had become a ventilator-dependent quadriplegic as a result of a motor vehicle accident at age five.

He lived at home. A respiratory therapist dropped in during the day and nurses stayed with him day and night.

At 1:30 a.m. his night nurse found him pale and cold. The parents called 911. The paramedics could do nothing for him and pronounced him at 1:45 a.m.

The family's lawyers subpoenaed the flow sheets and the ventilator itself.

The low-pressure alarm was set below the value in the physician's orders.

The day and night nurses testified they left the alarm setting as it was and filled out falsified flow sheets after the patient's death.

COURT OF APPEALS
OF NORTH CAROLINA
October 4, 2011

Paradoxically the Court of Appeals of North Carolina dismissed the day and night nurses and the respiratory therapist from the case. The family's lawyers waited almost four years to name them in the lawsuit, which was long past the statute of limitations in North Carolina.

A lawsuit was filed shortly after the incident against the nurses' and respiratory therapist's corporate employers.

Evidence subpoenaed in the lawsuit implicated the top-copy nursing care flow sheets as forgeries. Carbon copies in the chart showed the low-pressure alarm on the ventilator was set by the respiratory therapist below the value in the doctor's orders. The nurses left the ventilator alarm alone even though they knew it was wrong because the respiratory therapist did not tolerate them making any changes. **White v. Maxim Healthcare, 2011 WL 4553130 (N.C. App., October 4, 2011).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

X-ray Search For Contraband, With Search Warrant: Patient's Rights Were Not Violated.

After the suspect was arrested for driving without a license the police officers were informed that he had secretly inserted a packet of drugs into his rectum.

Based on this information, with the suspect still in custody, the police obtained a search warrant to search his anal cavity for drugs.

He was taken to a nearby hospital emergency room. The E.R. nurse noted on the intake form that the purpose of his visit was a warrant cavity search for drugs with police present.

The E.R. physician verified that the police had a search warrant and then performed a digital exam of the patient's rectum. The patient strenuously objected to the procedure but did not attempt to resist.

No contraband was discovered during the digital exam, so the physician ordered a standard kidney/ureter/bladder x-ray. The patient was still adamant that he did not consent, but again he did not attempt to resist.

The x-ray was read by a radiologist. There was nothing in the anal cavity. The suspect was released without being charged with anything more serious than driving without a license.

The suspect sued the police officers for violating his Constitutional rights. The US Court of Appeals for the First Circuit ruled his rights were not violated.

X-ray Used for Body-Cavity Search

A medical x-ray, like a manual body cavity search or a blood draw, is appropriate without the patient's consent if the police have probable cause that evidence of a crime will be found and the procedure is done by medical professionals according to professional medical standards.

A search warrant is not necessary if the police have probable cause. However, the Court pointed out that a search warrant provides an extra layer of legal protection to the police and the medical professionals by placing them on solid ground on the question whether probable cause did exist, in case their actions are later challenged in court.

In contrast, forcing a suspect to undergo surgery, for example to extract a bullet for forensic ballistic testing, is never appropriate.

It was not relevant that the x-ray imaged other parts of the body beyond the anal cavity itself, the Court said. **Spencer v. Roche, __ F. 3d __, 2011 WL 4916925 (1st Cir., October 18, 2011).**

Labor & Delivery: Physician Did Not Depart From Accepted Practice, Nurses Not Liable In Suit.

The mother had to undergo a cervical cerclage procedure five months into her pregnancy with triplets.

Soon after that she began a series of admissions to the hospital for vaginal bleeding. During the last of these visits the plan was observation, bed rest and administration of tocolytic medication.

The mother began to experience nausea, vomiting, continued vaginal bleeding and low blood pressure.

The mother's obstetrician decided to do an emergency cesarean and delivered the babies at 30 1/2 weeks gestation. During the procedure it was discovered that the cerclage had eroded through the mid and posterior portions of the cervix.

The babies were diagnosed with brain damage sustained either in the uterus or during the cesarean procedure.

The nurses who cared for the mother were not expected to exercise independent medical judgment in her treatment.

None of the actions or orders of the attending physicians were clearly contraindicated or so far outside the realm of accepted obstetrical practice as to require the nurses to inquire with the physicians or to advocate on the mother's behalf.

NEW YORK SUPREME COURT
APPELLATE DIVISION
October 11, 2011

The New York Supreme Court, Appellate Division, dismissed the parents' lawsuit as it pertained to the nurses who cared for the mother during her last visit.

Labor and delivery nurses are not expected by the law to exercise independent medical judgment apart from following the orders and carrying out the plan of the attending physician.

Only if the labor and delivery nurses observe actions or receive orders from the attending physician or physicians which are clearly contraindicated by accepted obstetrical practice are the nurses required to inquire as to the correctness of what is going on or to advocate through the nursing chain of command for a different medical course. **Bedard v. Klien, __ N.Y.S.2d __, 2011 WL 4839159 (N.Y. App., October 11, 2011).**