LEGAL EAGLE EYE NEWSLETTER

October 2006 *For the Nursing Profession* Volume 14 Number 10

# Nurse Finds Illegal Contraband In Patient's Clothing: Patient's Rights Were Not Violated.

A man was taken to the emergency room at a state-operated hospital following a motor vehicle accident.

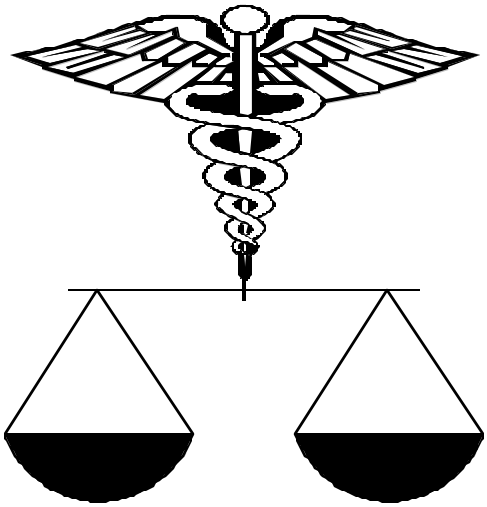
Following standard hospital practice for inventorying the patient's property, the nurse unzipped a pocket in the patient's coat. She found cocaine and ammunition.

The nurse notified her supervisor. The items were turned over to the police officer who had accompanied the patient to the hospital. The officer read the patient his Miranda rights and questioned him. The patient admitted the items were his and consented to a search of his car where a firearm and digital scales were found.

**Nurse Not Acting Along With Law Enforcement**

The US District Court for the Eastern District of Kentucky ruled there was no violation of the patient's Constitutional rights.

The court contrasted this case with a 2001 US Supreme Court case which ruled that hospital personnel did violate their patients' rights. In that case hospital personnel worked directly with law enforcement by obtaining urine samples from pregnant women to test for illegal drugs, ostensibly to use the threat of criminal prosecution to force them into addiction treatment.



***The police officer did not communicate with the nurse about possible criminal activity before the nurse checked the pockets of the patient's coat.***

***The hospital's policy is reasonable. It serves to prevent injury to patients and hospital staff and to protect the hospital from potential liability.***

UNITED STATES DISTRICT COURT
KENTUCKY
August 17, 2006

A caregiver risks violating a patient's Constitutional rights if the caregiver has an understanding with law enforcement that the caregiver will search the patient's person or personal property on behalf of law enforcement for possible evidence of criminal activity.

**Nurse Was Following Established Hospital Procedures**

The nurse in this case found the evidence accidentally in the course of routine healthcare treatment, not while trying to find grounds to incriminate her patient.

The nurse was only following hospital procedures, as she understood them, which required her to remove, log and inventory a patient's clothing and personal property so that treatment could be given and so that the hospital would have a record of the patient's property to protect the hospital if the patient later accused the hospital of losing or stealing something.

There is no requirement of probable cause or need for a search warrant for a nurse to search a patient's clothing and personal property if the nurse is simply following hospital policy and is not acting under the direction of law enforcement.

Like any other citizen, once evidence of a crime is found a nurse has the legal obligation to turn the evidence over to law enforcement. **US v. Clay, 2006 WL 2385353 (E.D. Ky., August 17, 2006).**

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# Confidentiality: Kids Allowed To Copy Charts.

A nurse worked for both physicians in a two-physician office practice.

The two physicians decided to dissolve their business partnership. One of them would move out and open a separate office in the same building.

The nurse was saddled with the job of coming in on a Sunday while the office was closed to photocopy the charts of the patients of the doctor who would be leaving.

The nurse brought her two children, ages eleven and thirteen, with her to help with the photocopying. The doctor had agreed to pay the children for helping out.

However, when the other doctor happened to come in and saw the children with the charts he quickly put a stop to the copying operation. His office manager filed a complaint against the nurse with the state board of nursing for violation of patients' medical confidentiality.

***The children were not allowed to read the charts, only to feed the pages into the copy machine and press the "start" button.***

***No confidential information left the doctor's office.***

***The children were paid by one of the doctors for their work.***

COURT OF APPEALS OF IOWA
August 23, 2006

The Court of Appeals of Iowa overruled the state board of nursing. The court found no unethical conduct.

The children were closely supervised so that they did not read the information in the charts. They only performed manual tasks involved in the photocopying. No confidential information left the office. **Hoffman v. Iowa Bd. of Nursing, 2006 WL 2421643 (Iowa App., August 23, 2006).**

# Confidentiality: Phone Contact With Family Member Ruled Improper.

A staff member in a family-practice physician's office was told to contact the patient about her test results just received from the lab.

The lab report indicated the patient was suffering from severe anemia. It was necessary for the patient to contact the doctor's office immediately for medical follow up.

The staff member used a number from the file to phone the patient's husband at work. She elaborated about the fact that his wife's lab test report indicated severe anemia and thus she needed to get in touch with the doctor immediately.

The patient sued the medical clinic for violation of medical confidentiality.

***The task delegated to the office staff member was simply to locate the patient and have the patient contact the physician's office.***

***That task could and should have been performed without having to reveal confidential medical information.***

COURT OF APPEALS OF GEORGIA
September 6, 2006

The Court of Appeals of Georgia was willing to uphold the basic premise of the lawsuit, leaving open the question how the patient would be able to prove she suffered actual harm as a result of the clinic staff member's improper conduct.

Just telling the husband it was very important for the patient to contact the doctor immediately would and should have sufficed in this situation. **Howell v. Shumans, __ S.E. 2d __, 2006 WL 2555979 (Ga. App., September 6, 2006).**

# Organ Donation: Court Faults Donor Screening.

The Superior Court of Massachusetts ruled recently that two registered nurses employed by an organ bank who were involved in the screening and evaluation of a now-deceased recipient's transplant liver must share legal liability with the other healthcare professionals who were sued by the recipient's widow for malpractice and wrongful death.

**Lymphadenopathy on Chest X-rays Metastasis to be Ruled Out**

Specifically, according to the court record the donor died from a rare brain cancer. While still alive his chest x-rays had revealed evidence of lymphadenopathy. The court believed these facts warranted concern as to the possibility of metastasis to the liver and other organs which would have made his organs unsuitable for transplantation. The recipient in fact died from metastatic cancer present in his transplant liver. **Gonzales v. Katz,, 2006 WL 2424820 (Mass. Super., July 19, 2006).**

# Back Problems: FMLA Leave For Chiropractic.

The US Circuit Court of Appeals for the Tenth Circuit recently pointed out that the US Family and Medical Leave Act gives employees the right to medical leave for treatment only if it is a serious health condition.

Under US Department of Labor regulations a nurses aide's back problem being treated by a chiropractor can qualify as a serious health condition, but the regulations expressly say this is true only if the chiropractor is treating spinal subluxations that have been revealed by x-ray. **Silcox v. Via Christi Regional Medical Center, 2006 WL 2536602 (10th Cir., September 5, 2006).**

# Elopement: Detox Patient's Actions Not Foreseeable.

The chronic alcoholic patient was in acute withdrawal when his wife brought him to the rehab center. The physician convinced the patient to admit himself and took him to the nurses station.

The nurse started taking vitals and gave the 25 mg of Librium the doctor ordered. Soon, however, it appeared from his rising BP that his withdrawal was more severe than thought and he needed more Librium. The nurse believed she had a rapport with the patient. He seemed to understand she needed to step away to phone the doctor for more medication to help him with his symptoms.

The nurse took three steps away. The patient got up and ran out. As he ran he had a seizure, fell, hit his head and died.

**Elopement Attempt Not Foreseeable**

The Court of Appeal of Louisiana ruled the nurse did nothing wrong. The nurse had no reason to foresee what happened. The court dismissed the widow's lawsuit. **Ball v. Charter Behavioral Health, __ So. 2d __, 2006 WL 2422866 (La. App., August 23, 2006).**

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# Elopement Attempt: Psych Patient Can Sue For Injuries.

***A facility caring for the mentally ill has a legal responsibility to protect patients from the consequences of their own dangerous behavior.***

***Any room where a patient can go and not be seen must have a window security screen. A no-patient-access room should always be locked.***

***The three patients had been in pajamas all day, until about 5:00 p.m., then all at once appeared dressed in street clothes and shoes.***

***The linen closet was right next to the nurses station. The nurses should have noticed them and been suspicious what the now-fully-dressed patients were doing in the linen closet.***

***The patient was on thirty-minute observation. The procedure for eyeballing each and every patient every thirty minutes was not being followed.***

SUPREME COURT OF MISSISSIPPI
August 24, 2006

The twenty-five year-old patient's diagnoses were schizophrenia and borderline personality disorder. She was considered a danger to self and others, had attempted suicide three months earlier, was on a locked unit and had recently been argumentative with staff.

Believing she was about to be transferred to another unit where abuse was rumored to occur, she and two others tried to escape by tying bed sheets together to make a rope and climbing down from a third-story window. She fell and sustained a serious leg injury that required eight surgeries and left her physically permanently disabled. She was already deemed to have a psychiatric total disability.

The Supreme Court of Mississippi approved a $1,000,000 verdict for her.

They went out the window of a conference room. The conference room had no patient-security window screen because it was not considered a patient-access area. The door should have been locked.

The linen closet on a locked psych ward should also have been locked.

The patient was on close observation. Staff were required to verify her whereabouts and activities q thirty minutes. The court accepted testimony the patient-care aides were all watching television and not paying attention to their patients.

**Elopement Attempt Foreseeable**

The patient just minutes before was crying hysterically expressing her anxiety to staff over her rumored transfer. That should have alerted staff to an acute elopement risk, the court said. **Dept. of Mental Health v. Hall, __ So. 2d __, 2006 WL 2437830 (Miss., August 24, 2006).**

# Self-Harm: Courts Faults Psych Facility.

The patient was admitted to the hospital's psychiatric unit for what the Court of Appeals of Texas described as bizarre and delusional behavior.

While a patient on the unit she was found to have severe caustic chemical burns on her feet. The injuries were assumed to be self-inflicted.

The court found the evidence inconclusive that the hospital was negligent for failing to discover these injuries at the time of admission. However, that left open only one possibility, that the injuries were somehow self-inflicted while the patient was in the hospital.

Nevertheless, the court stated what it believed were relevant elements of the standard of care at the time of admission and during a patient's stay in a psychiatric facility.

**Admission Assessment / Exam**

A psychiatric facility should carefully inspect the entire body and contents of clothing and shoes. A thorough medical physical exam should be done.

A history should be obtained from the patient, but the facility should not rely solely on what the patient says. Instead, family members and others should be questioned about the patient's condition and recent activities.

An attempt should be made to try to get the patient to understand and collaborate with needed medical interventions such as administration of medications.

**Ongoing Assessment / Observation**

The court stressed the importance of close, frequent observation of a psychiatric patient to ascertain the patient's location and activities. Psychiatric patients must be assumed always to be at risk for self-harm and/or elopement.

The court accepted as an expert witness an advance practice registered nurse certified as a specialist in adult psychiatric and mental health nursing. **In re Baptist Hospitals of SE Texas, 2006 WL 2506412 (Tex. App., August 31, 2006).**

# Drugs Were In "Plain View," Nurse Did Not Violate Patient's Rights.

An individual was taken to the hospital by ambulance after an automobile accident.

An RN and other hospital personnel removed his clothing in the process of assessing the extent of his injuries.

A pill bottle fell out of one of his pockets. Wanting to know what medications the patient was taking, so that that fact could be reported to the physicians, the nurse opened the pill bottle.

The pill bottle contained plastic baggies of a substance the nurse thought might be illegal drugs, i.e., cocaine or methamphetamines.

The nurse called hospital security. The hospital security guard, believing the substance to be illegal drugs, called the police. A police officer came to the hospital, took the pill bottle and its contents into evidence, read the patient his Miranda rights, questioned him, got his consent for a blood test, field-tested the contents of the pill bottle positive for methamphetamine and was informed the hospital lab's blood test was also positive for methamphetamine.

The patient was convicted of possession of methamphetamine. The Court of Appeals of Kansas ruled out arguments that his Fourth-Amendment Constitutional rights were violated.

**The Pill Bottle Was In "Plain View"**

The court ruled the nurse, the hospital's security guard and the police officer each acted lawfully.

According to the court, the pill bottle was found on the patient's person in the course of necessary, good-faith medical care, not in the course of a police search. That meant it was in "plain view." No search warrant was needed to open it and determine its contents. **State v. Welch, 140 P. 3d 1061 (Kan. App., August 25, 2006).**

# Birthing Bed Collapses: Nurse Midwife Held Liable.

The New York Supreme Court, Appellate Division, has ruled that a certified nurse midwife working for a physicians' ob/gyn practice can be held liable along with her employer for injuries sustained by the patient during childbirth.

A nurse midwife is responsible for understanding how properly to attach and adjust the foot segments of the birthing bed to prevent patient injury. **Aiosa v. Mercy Medical Center, __ N.Y.S. 2d __, 2006 WL 2258017 (N.Y. App., August 8, 2006).**

# Assisted Living: Facility Liable For Murder By Resident.

A resident of an assisted living facility murdered another resident. The District Court of Appeal of Florida ruled the victim's family had the right to sue the facility for negligence.

The murderer had been in a psychiatric facility for dementia. While in the hospital he was considered a danger to self and others. On admission to assisted living he was diagnosed with major depressive disorder, dementia and psychosis. He was sent to a psych hospital when he told facility staff he felt he could hurt himself or others, but was released. Then when his daughter became concerned about his increasing paranoia, his psychiatrist prescribed anti-psychotic medication.

The man was in need, and the psychiatrist wrote orders for his mental status and medication compliance to be monitored by a psych nurse, but no such nursing care was provided by the facility. **Pollock v. CCC Investments, 933 So. 2d 572 (Fla. App., May 24, 2006).**

# Misconduct: Was Care Plan Communicated To Fired Aide?

An aide was terminated from his job at a nursing home for attempting a solo transfer of a patient from her bed to her wheelchair without a gait belt and without help from another staff person.

He believed he was not terminated for just cause and filed for unemployment.

The state department of workforce development ruled he was terminated for just cause and denied his unemployment claim. The Court of Appeals of Indiana, however, ordered the department to give his case another hearing.

**Care Plans**
**Must Be Communicated To Staff**

The court found the evidence thus far inconclusive that the requirements of this patient's care plan were effectively communicated to the aide.

Assignment sheets for the patients were kept in a notebook at the nurses station, but it was not clear the aide was ever instructed to review the assignment sheets or supervised to see that he did. Effective communication of what is expected is one of many basic duties of a supervisor. **Steele v. Dept. of Workforce Development, __ N.E. 2d __, 2006 WL 2521443 (Ind. App., September 1, 2006).**

# Identity Theft, Vulnerable Victim.

The US Court of Appeals for the Fourth Circuit has upheld the US Department of Justice sentencing guidelines that impose especially severe penalties for offenses against vulnerable victims, in this case an elderly nursing home patient whose bank account was emptied by a certified nursing assistant who stole her personal information. **US v. Ashworth, 2006 WL 2591933 (4th Cir., September 7, 2006).**

# Incident Reports: Court Discusses Extent Of Quality Review Privilege.

***An incident report or risk management report and its contents are not subject to discovery in a civil lawsuit nor are they admissible in evidence at trial. These documents and their contents are considered privileged.***

***The term "discovery" refers to the required pre-trial disclosure of information to the other side, information that is properly subject to discovery under pertinent statutes and rules of court.***

***The privilege specifically targets documents that report incidents involving injury or potential injury suffered by a patient while receiving medical care by a healthcare provider.***

***However, the privilege applies only if the incident report was prepared for use by a peer-review or quality assurance committee that functions internally to review patient-care incidents candidly with a view toward improving the quality of patient care.***

***Merely labeling a document an "incident report," in and of itself, does not invoke the privilege.***

COURT OF APPEALS OF OHIO
August 11, 2006

The underlying lawsuit against the outpatient rehab facility arose from an incident involving a husband and wife who were both coming in for medical care.

The husband was being treated by a respiratory therapist for his emphysema. The wife was recuperating from open-heart surgery.

The husband's respiratory therapist disconnected his portable $O_2$ tank and connected him to the wall port with a lengthy hose. The wife got up from where she was sitting to go into the restroom to attach her cardiac monitors, the usual procedure before her therapy started. She tripped and fell over the husband's oxygen hose.

There has been no ruling as yet on the validity of the underlying lawsuit alleging negligence against the facility.

The issue now is whether the patients' lawyers are entitled to a copy of the incident report. The Court of Appeals of Ohio ruled the report is legally privileged and the patients' lawyer may not see it.

**Peer-Review / Quality Assurance**

To make its point the court looked at a contrasting case where the patient's lawyer was entitled to see the incident report. In that other case the facility merely labeled its incident report as an "incident report." There was no indication in that case that the report was to be used and would be used by the facility's peer-review or quality assurance committee, or even that the facility had a peer-review or quality assurance committee.

In this case, on the other hand, the facility's risk manager, a registered nurse, testified through a sworn affidavit that the incident report was prepared for use internally by the Risk Management and Quality Assurance Committee and that it would be used in an effort to improve the quality of patient care within the facility, which was the committee's function. That was enough for the court. **Quinton v. Medcentral Health System, 2006 WL 2349548 (Ohio App., August 11, 2006).**

# Bed Rails: Court Discusses Legal Liability Considerations.

The Court of Appeals of Michigan used a seemingly straightforward bed rail case as a springboard to touch on many of the legal issues now being seen in these cases.

The case involved a nurse who apparently left the bed rails down after taking vital signs at 3:00 a.m. and the patient ended up on the floor.

**Professional Malpractice versus Ordinary Negligence**

Courts are saying that the decision to raise or leave down the bed rails is a matter of a caregiver's professional judgment.

The legal upshot is that such cases cannot be submitted to a jury of untrained lay persons without expert testimony. Some states also require the patient's attorney to file an affidavit of merit or an expert witness's report or to go before a medical review panel before a malpractice case can be filed in court.

**Bed Rails as Physical Restraints**

Courts are saying that the bed rails are a physical restraint that require a physician's order based on individualized assessment of the patient's needs.

**Positional Asphyxia**

The risk of bed rail strangulation is a major patient-safety and legal-liability consideration.

Although not an issue in this case, the court pointed out that healthcare facilities have an obligation to train staff to be alert to a bed rail strangulation risk with elderly and infirm patients. Some of them may be prone to involuntarily movements which can put them in dangerous positions in bed from which they cannot remove themselves on their own. They need to be positioned securely with pillows, wedges, rolls and/or restraints to keep them out of the bed rails which can pose a significant hazard. **Jackson v. Harper Hosp., 2006 WL 2613599 (Mich. App., September 12, 2006).**

# Huntington's Chorea: Care Faulted Because Of Poor Nursing Documentation.

The patient died at age thirty-eight with Huntington's Chorea. The immediate cause of death was sepsis from methicillin-resistant staph infection in a sacral skin ulcer.

The Court of Appeal of California noted that Huntington's is a progressive genetic degenerative condition for which there is no cure which is usually fatal within ten to fifteen years. It places the patient at high risk for skin breakdown.

When she entered the rehab facility her skin was basically intact. Her care plan nevertheless called for frequent repositioning, daily monitoring of skin integrity and for her physician and family to be notified of redness or skin breakdown.

***When the patient was admitted to the hospital the patient had lacerations on her toes and feet with poor skin condition on both buttocks. Her heel was bruised and had areas of redness.***

***The rehab center where she came from, however, had no documentation of her skin condition.***

COURT OF APPEAL OF CALIFORNIA
September 13, 2006

The court found telling evidence to support the family's lawsuit against the rehab facility. Documentation of major loss of skin integrity, obvious when she was taken from the rehab facility to a hospital, was not even mentioned in her rehab chart. The court reasoned that the facility could not have been taking care of her needs. **Sababin v. Superior Court, 2006 WL 2615418 (Cal. App., September 13, 2006).**

# Latex Allergy: Court Upholds Nurse's Legal Rights.

A nurse is entitled to workers compensation for a latex allergy caused by exposure to latex gloves in the workplace. In this case the Supreme Court of Tennessee Special Workers' Compensation Appeals Panel approved an award of 50% total disability; the nurse was still capable of working in latex-free settings.

In an occupational disease case the worker becomes entitled to workers comp when the worker first has to miss work for the physical complications of the occupational disease. The legal upshot is that that is when the statute of limitations starts to run for filing of a claim. It may also determine which employer will be answerable for the worker's claim, unless there is subsequent exposure to latex at another job which the doctors will say aggravated the condition. Workers comp laws vary from state to state and it is best to see a lawyer. **Huffaker v. St. Mary's Health System, 2006 WL 2522141 (Tenn. Work Comp., September 1, 2006).**

# Our Newsletter Online.

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# Medicare: Three Days Of Prior Inpatient Care To Qualify For Skilled Nursing Do Not Include E.R., Observation Time.

The US District Court for the District of Connecticut agreed to make a class-action ruling in a lawsuit challenging the US Department of Health and Human Services's interpretation of what hospital inpatient status means for determining if a Medicare beneficiary has been an inpatient for at least three days before transfer to post-hospital skilled nursing.

**Emergency Room, Observation Time Do Not Count Toward Three Days As Inpatient**

In a nutshell, the patients' class-action lawsuit contended that time in the hospital emergency room and under observation pending a decision to admit or to discharge should count toward the three days a patient must spend as a hospital inpatient before Medicare will cover post-hospital skilled nursing services.

Certain medical associations filed legal briefs with the court supporting the patient/plaintiffs' legal position.

The Department of Health and Human Services stood by its interpretation of the word "inpatient" for purposes of the three-day rule. The US District Court for the District of Connecticut has upheld the Department's current interpretation of that term.

Patients who spend time in the hospital emergency department or under observation, but who do not need three full days of actual inpatient hospital care, were not intended by Congress to qualify for Medicare skilled-nursing benefits, in the court's judgment.

The court believed Congress intended for Medicare only to provide benefits for post-hospital skilled nursing care for the more serious cases, that is, only for those cases where the patient had to be in the hospital for at least three days receiving hospital inpatient care. **Landers v. Leavitt, 2006 WL 2560297 (D. Conn., September 1, 2006).**

***The US Congress said in the Medicare Act that post-hospital extended care services in a skilled nursing facility are covered only when the beneficiary has been transferred to the skilled nursing facility from a hospital in which the beneficiary was an inpatient for not less than three consecutive calendar days before discharge from the hospital in connection with the transfer.***

***CMS Medicare Benefit Policy Manual (CMS Pub. 100-2, ch. 1, § 10) contains the Department of Health and Human Services's current interpretation of the term "inpatient."***

***An inpatient is one who has been admitted to a hospital for bed occupancy for purposes of inpatient hospital services with the expectation he or she will remain at least overnight.***

***Physicians should use a 24-hour benchmark, that is, they should admit patients who will need care more than 24 hours, and treat the rest as outpatients.***

UNITED STATES DISTRICT COURT
CONNECTICUT
September 1, 2006

# Flu Vaccine: New Recommendations, Information Materials From CDC.

The US Centers for Disease Control and Prevention (CDC) has a new (June 30, 2006) version of the approved vaccine information materials for influenza vaccines to be used during the 2006-2007 flu season.

According to the CDC, the only things new in the June 30, 2006 version compared to the October 20, 2005 version of the flu vaccine information materials are the CDC's recommendations that all children 6-59 months of age be vaccinated, that is, with inactivated flu vaccine, and that all adults in contact with such children also be vaccinated, with a form of flu vaccine appropriate for the adult.

More complete information, including the approved vaccine information statements for flu and other vaccines, can be obtained from the CDC's website: http://www.cdc.gov/nip/publications/VIS.

FEDERAL REGISTER, August 24, 2006
Pages 50065 – 50066

# Gifts From Patients: Wrong, But Not Theft.

The Superior Court of Connecticut upheld a nursing-home admissions counselor's right to sue for defamation after her former employer told others she was fired for theft of a patient's property.

Even though the patient really did say she wanted the counselor to have her furniture after she died, it was an error in judgment, a violation of company policy and a valid basis for termination for the counselor to accept such a gift of personal property from the family of a deceased patient. However, it was not theft. **Gambardella v. Apple Health Care, Inc., 2006 WL 2556300 (Conn. Super., August 9, 2006).**

LEGAL EAGLE EYE NEWSLETTER
*For the Nursing Profession*

# IV Not Changed: Court Upholds Nurses' Judgment.

The patient was in the hospital eighteen days for treatment of stomach ulcers.

Ten days into his stay he developed sepsis at an antecubital IV site. He had to have surgery to drain the abscess and reconstruct the vein in his arm.

His lawsuit pointed to the hospital's standing policy that IV sites were to be moved at least every seventy-two hours. His lawsuit argued that failure to follow the hospital's standing policy for changing IV sites caused the sepsis which led to the complications.

The Court of Appeals of Mississippi, however, accepted the testimony of the hospital's nursing expert witness that the nurses were not negligent. Sometimes the nurse's judgment is that it is better to leave an IV alone, especially when there was significant trouble getting a working IV puncture for the patient in the first place. **Lander v. Singing River Hosp., __ So. 2d __, 2006 WL 1985476 (Miss. App., July 18, 2006).**

# HIV: Test Results Pending, Discharge Instructions Must Stress Patient Follow Up.

The Superior Court of New Jersey, Appellate Division, has ruled that physicians and nurses have the responsibility, when a patient's HIV test has been sent to the lab, but the result is not known at the time of discharge from the hospital, to counsel the patient to follow up to obtain the test results.

When a positive HIV test comes back from the lab for a patient who has already been discharged, the patient must be contacted.

The court ruled that the HIV+ patient's spouse and as-yet-unborn child are persons who can potentially sue the patient's caregivers and the hospital for failing to carry out this important responsibility. **C.W. v. The Cooper Health System, __ A. 2d __, 2006 WL 2590107 (N.J. App., August 10, 2006).**

# Discrimination: Alzheimer's Patient's Racial Slurs Do Not Create A Hostile Work Environment.

An African-American certified nursing assistant worked in a nursing home which primarily cared for elderly persons with Alzheimer's, other dementias and schizophrenia.

A seventy year-old Alzheimer's patient who had been schizophrenic since age thirteen began directing vehement racial slurs against the CNA, including frequent use of the word "nigger." The patient, who was Hispanic, also made racial remarks against Hispanics and Caucasians.

The CNA complained to management but they did nothing about it. The CNA was eventually fired for making physical threats against the patient in question and then lying about abuse of the patient during the ensuing internal investigation.

***Persons caring for Alzheimer's patients work under circumstances that are unique to their chosen profession.***

***These patients are unable to understand or control what they say and do.***

***It is not reasonable to perceive such a workplace as a racially hostile environment solely because of statements made by mentally impaired patients.***

UNITED STATES COURT OF APPEALS
FIFTH CIRCUIT
September 1, 2006

The US Equal Employment Opportunity Commission sued the nursing home on the CNA's behalf. The US Circuit Court of Appeals for the Fifth Circuit, however, dismissed the suit.

Ordinarily a business must protect its employees from racial harassment by the business's customers. Failing to do so amounts to fostering a racially hostile work environment and is considered a form of racial discrimination.

However, according to the court, caregivers working with persons who are unable to understand or control their speech and actions work under special circumstances. They cannot take their patients' racial remarks personally as indications of a racially hostile environment. **EEOC v. Nexion Health, 2006 WL 2528432 (5th Cir., September 1, 2006).**