LEGAL EAGLE EYE NEWSLETTER

October 2007 **For the Nursing Profession** Volume 15 Number 10

Disability Discrimination: Quad On Ventilator Could Not Communicate With His Caregivers.

A forty-nine year-old male ventilator-dependent quadriplegic spent four weeks in the hospital for pneumonia.

His Passy-Muir valve was disconnected on admission when he was placed on the hospital's ventilator. That is a device which makes it possible for tracheostomy patients to speak, whether or not they are on a ventilator.

The hospital had call lights activated by pillow switches that function much the same as ordinary call buttons except they can be activated by a turn of the head by quadriplegic patients who cannot use their hands.

The nurses requested a pillow switch but were told none was available as they were all being used by the hospital's long-term quadriplegic patients.

The patient experienced three episodes of respiratory difficulty, two of which were discovered by family members, not his nurses, during which he could basically do nothing but hope that someone would find him in time.

The legal basis for the patient's lawsuit against the hospital was disability discrimination. The damages claimed were for mental anguish and emotional distress. There was no claim the patient suffered any direct physical injury during his respiratory crises.

The ADA requires hospitals to provide assistance devices to patients with communication-related disabilities so that these patients can communicate with caregivers as effectively as non-disabled patients.

It is a basic tenet of nursing practice that patients must be given the ability to communicate with their caregivers.

SUPERIOR COURT, LOS ANGELES COUNTY CALIFORNIA
July 5, 2007

The Americans With Disabilities Act (ADA) has separate but very similar language for private and public hospitals.

Private-sector hospitals commit disability discrimination when they fail to take such steps as may be necessary to ensure that no individual with a disability is excluded, denied services, segregated or otherwise treated differently because of the absence of auxiliary aids and services, unless the hospital can demonstrate that taking such steps would result in an undue burden to the hospital.

Public-sector hospitals are required by ADA regulations to take appropriate steps to ensure that communications with disabled patients are as effective as communications with others and to furnish appropriate auxiliary aids and services to afford an individual with a disability an equal opportunity to participate in obtaining services. In determining what type of auxiliary aid or service is necessary primary consideration is to be given to the requests of the disabled individual.

The patient's lawsuit against the hospital in the Superior Court, Los Angeles County, California was settled for $295,000 during trial, right before the patient himself was scheduled to testify before the jury. **Parco v. Pacifica Hosp., 2007 WL 2491516 (Sup. Ct. Los Angeles Co., California, July 5, 2007).**

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October 2007

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US False Claims Act: Nurse's Suit Thrown Out.

A hospital charge nurse filed suit against her former employer for violation of the US False Claims Act.

The US False Claims Act allows a private individual to file a civil lawsuit on behalf of the United States, and to keep a substantial percentage of the proceeds recouped from any person or corporation who has made a false or fraudulent claim against any US Government agency.

UNITED STATES DISTRICT COURT
ILLINOIS
August 29, 2007

The nurse's lawsuit raised vague allegations that drug detox, treatment and therapy patients were admitted who did not meet admission requirements, were upcoded as to the severity of their problems, were not treated by doctors who supposedly treated them and that treatment records were sometimes "fudged" at the doctors' insistence.

The US District Court for the Northern District of Illinois threw out the case. Not unmindful of the law's important purposes, the courts still insist that a private citizen filing suit under the US False Claims Act have detailed support for allegations of fraudulent billings including patient identification numbers, dates, amounts and solid proof exactly why the bills are fraudulent.

Private individuals are not allowed to file suit against a healthcare provider, then use the court processes to go on a "fishing expedition" looking for evidence to support the lawsuit. **US v. Thorek Hosp., 2007 WL 2484333 (N.D. Ill., August 29, 2007).**

Twin Delivery: Nurses Ruled Not At Fault.

The patient was admitted to the hospital by her obstetrician.

An ultrasound at the hospital revealed that she was carrying twins, one in a normal vertex position, the other in an inverted breech position.

The obstetrician, assisted by two hospital labor and delivery nurses, delivered the normally-positioned vertex baby relatively quickly and without complications.

With the second baby, however, things did not go smoothly. The doctor deemed it necessary to go ahead with external version, that is, he had both nurses push on the abdomen while he also pushed with one hand and reached in with the other to reorient the baby head-first.

The patient must prove the link between negligence and harm to the patient.

It was inconclusive that caregivers' negligence damaged the baby's brain.

SUPREME COURT OF ALABAMA
August 31, 2007

The monitors had to be removed because they were in the way. The mother complained vigorously that the procedure was very painful and insisted they stop and do a cesarean.

The second baby was born with water filling both brain hemispheres. He lived in a vegetative state until he died at age six.

The Supreme Court of Alabama threw out the jury's $3,800,000 verdict. The court found no basis for the patient to claim that by taking off the monitors, not getting blood gases, etc., the nurses were neglecting to monitor the course of labor during the second delivery or to claim that stopping the whole process in favor of a cesarean was realistic at the point she started complaining. **Long v. Wade, __ So. 2d __, 2007 WL 2459976 (Ala., August 31, 2007).**

ECT: Patient Burned, Cause Disputed.

The Court of Appeals of Ohio ruled the local county court judge erroneously rushed to judgment that the patient's caregivers were not at fault. The Court reinstated the patient's lawsuit.

There are several plausible explanations for the fire.

It is not clear if the patient's doctor or nurse were at fault, but the patient is at least entitled to her day in court before a jury.

COURT OF APPEALS OF OHIO
July 13, 2007

The patient got second- and third-degree facial burns from a fire that started just as current was activated through the electrodes attached to her head for electroconvulsive therapy (ECT).

The nurse testified the flames started at the electrode at the side of her head and were fueled by maximum-flow O_2 from a wall port leaking from her mask.

The patient's medical expert traced the flames to a spark arching from one electrode to the other due to flammable hairspray or face cream or antiseptic used to clean and prep the skin for the electrodes, with the O_2 vigorously contributing to the fire once it started.

The patient's expert was equivocal, however, when it came to assigning blame. He admitted he could not say if the patient's nurse or physician improperly prepared or prepped the patient for her procedure, improperly secured one or both of the electrodes on her skin or if, instead, there was an unexpected and unexplained malfunction of the equipment in use.

However, as the court said, "Medical treatment should not involve setting a patient's head on fire." **Powell v. Hawkins, 2007 WL 2019802 (Ohio App., July 13, 2007).**

Suicide In Psychiatric Facility: Jury Finds Psychiatric Patient's Caregivers Not At Fault.

The jury in the Superior Court, Sacramento County, California heard testimony outlining the full sequence of events leading up to a psychiatric patient's tragic suicide and concluded that the patient's caregivers were not at fault.

The fifty-seven year-old female patient had a history of alcohol abuse, depression and a previous suicide attempt.

She began drinking heavily and while intoxicated attempted to commit suicide by taking an overdose of Antabuse.

When that did not work, according to the history she gave her caregivers, she thought about hanging herself but instead called 911. Paramedics came to her home and took her to the emergency room where a seventy-two hour involuntary psychiatric hold was initiated.

The hospital transferred her to a psychiatric facility with a locked unit. She was kept on fifteen-minute suicide watch until she told her nurse she was no longer suicidal. The nurse phoned the psychiatrist for orders to transfer her to the adult treatment program, believing a less restrictive environment would be more beneficial for the patient than the locked ward.

While in the adult treatment program the nursing staff continued to monitor her status every thirty minutes. She went to group, signed a safety contract and agreed she would cooperate in her own treatment.

The same day she arrived the psychiatrist came in and saw her. She denied current suicidal intent and talked about recent family stressors in her life. The doctor diagnosed major depression and started her on antidepressant medication.

The next day she was withdrawn and anxious. She agreed to remain in the hospital voluntarily beyond her seventy-two hour involuntary commitment and to work on her problems. The doctor adjusted her antidepressants.

That evening the patient said she felt safe and agreed she was not going to attempt to harm herself.

Later that evening, however, she was found hanging in the shower. She was transferred to an acute care hospital to be maintained on a ventilator. A few days later her family gave permission to withdraw artificial life support based on the treating physicians' assessment that irreversible brain death had occurred.

As a general rule, the law judges caregivers by the quality of their care, not by the nature of the outcome. The jury could find no errors or omissions which fell below the legal standard of care.

It was not legally relevant one way or the other that the family elected to withdraw life support. **Soderman v. Smith, 2007 WL 2389564 (Sup. Ct. Sacramento Co., California, July 13, 2007).**

Involuntary Restraint: Court Dismisses Suit.

The patient had a history of multiple psychiatric admissions at the same hospital. Her diagnoses included dissociative identity disorder and substance abuse. She had eloped from the same hospital on a previous psych admission and was caught by hospital security and escorted back. She also had a history of self-mutilation.

This time she had an argument with her domestic partner, started drinking and then slashed her own arm with a kitchen knife. Paramedics took her to the hospital.

At the hospital she was placed in four-point restraints on orders from a psychiatric resident on duty.

The rationale for restraining her was to allow the nurses and a physician's assistant to treat her wound, to prevent further self-harm and to prevent elopement.

The emergency room nurse gave her an IM injection of Ativan. Once the patient calmed down the nurse removed the restraint strap on the patient's injured arm for her comfort.

The Superior Court of Connecticut agreed with the patient that Federal regulations do grant every hospital patient the right to be free from restraints of any form imposed as a means of coercion, discipline or for staff convenience or as retaliation by staff. Still she had no grounds to sue.

In this case use of restraints was backed by a physician's order, as required by law, and was directly related to fulfillment of the patient's physical and mental treatment needs. **Hanson v. Hospital of Saint Raphael, 2007 WL 2317825 (Conn. Super., July 20, 2007).**

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Neonatal Intensive Care: Nurses, Physicians Failed To Diagnose Imperforate Anus.

A medical and nursing malpractice lawsuit filed in the Superior Court, Riverside County, California resulted in a $10,000,000 pre-trial settlement.

The settlement was reported with a stipulation that the names of the patient, the hospital and the physicians remain confidential. The settlement was formally approved by the court on behalf of the infant, born November 23, 2004, on July 19, 2007.

Responsibility for payment of the settlement was split 50/50 between the neonatology medical group and the hospital which employed the neonatal nurses. The funds will go toward purchase of annuities to pay for a lifetime of special care for the baby's childhood and adult years.

The baby was born at 31 weeks gestation to an eighteen year-old mother with a history of illegal drug use who had received no prenatal care.

When she arrived at the hospital in active labor, 4 cm dilated and fully effaced, the mother tested positive for THC and amphetamines. Child Protective Services were notified and took immediate legal custody at birth. On a positive note, the baby's Apgar scores were 9 at birth and 9 shortly after, he weighed 1,248 grams and he was having no respiratory distress.

Neonatal Nursing Assessments

In the neonatal intensive care unit two hospital staff nurses, who could not be identified from the chart and did not testify, conducted the first nursing assessment. A rectal temperature apparently was obtained and was charted, which implied that rectal patency had been verified. The abdominal circumference was recorded as 22 cm.

A second exam was done by a neonatal nurse practitioner, also employed by the hospital. She charted, "Anus WNL – patent, rectal exam not merited."

Then the baby was seen by two neonatologists from the neonatology medical group. They were concerned about an elevated hematocrit but saw nothing else out of the ordinary.

Neonatal Nursing Care

During the first night a nurse changed the diapers and found no stool. By the next morning the abdominal circumference had increased slightly to 22.5 cm. An oral gastric tube was inserted on low intermittent suction and the baby was ordered to receive nothing by mouth.

The neonatologists continued to follow the infant for apnea and bradycardia.

On the morning of the second day a staff nurse measured the abdominal circumference at 26 cm. and noticed that the baby had not yet had a bowel movement. A third neonatologist from the medical group saw no cause for alarm.

Early that afternoon a staff nurse noted the abdominal circumference was now 27 cm. but did not feel it was necessary to notify the physician.

At 5:00 p.m. the diaper was changed. There was some stool the nurse was not able to wipe from the rectum. She did notify the neonatologist.

The neonatologist found a rectal fistula was starting. An x-ray revealed free air in the bowel, that is, the bowel had perforated internally and the contents were in the peritoneum.

The baby was transported to neonatal intensive care at a university hospital. Over time the baby had numerous surgeries for ruptured, torn and necrotic tissue within the intestines and for creation and revisions of a colostomy.

The child now requires constant home nursing care and will require total parenteral nutrition for the remainder of his life.

A neuropsychiatric evaluation has indicated the child may be facing mild mental retardation. It cannot be linked conclusively to the events surrounding his birth in the hospital, but it will more likely than not impact his ability to function independently managing his own TPN as an adult. **Confidential v. Confidential, 2007 WL 2363269 (Sup. Ct. Riverside Co., California, July 19, 2007).**

Fall Care Plan: Documentation Was Missing That Plan Was Carried Out.

An eighty-six year-old Alzheimer's patient fell in a nursing home and fractured her hip.

The patient's family had placed her in this particular facility because it had a philosophy against unduly restraining Alzheimer's patients, even those prone to injury from falling due to physical infirmity, mental confusion and memory loss.

The patient's lawyers complimented the facility for its no-restraint philosophy, but argued that the nursing and medical staff still should have seen the need for a bed alarm, a lower bed and/or cushioned mats on the floor near the bed to reduce the risk of injury from a fall.

The facility countered that it had a perfectly good fall-care plan, that is, the doctor's orders in the patient's chart required staff to check on her at least every two hours, yet the facility did not fully explain how checking her every two hours would have prevented her from falling .

Poor Nursing Documentation = Poor Nursing Care

Nevertheless there was no documentation in the chart that the fall-care plan, such as it was, was being implemented, that is, there was no documentation of the two-hour patient checks ever being done by her caregivers.

Incomplete nursing documentation sends a message to a jury that the patient's care needs are being neglected, even if there is no direct, concrete cause and effect relationship between the care that cannot be documented and the actual injury to the patient which resulted in the lawsuit.

The patient's lawsuit in the Court of Common Pleas, Philadelphia County, Pennsylvania resulted in a $500,000 jury verdict in her favor. **Logan v. New Courtland Elder Services, Inc., 2007 WL 2491724 (Ct. Com. Pl., Philadelphia Co., Pennsylvania, June 19, 2007).**

Patient's Fall: Patient Should Not Have Been Left Alone, Mishandled.

A thirty-seven year-old developmentally disabled woman lived in a six-bed adult foster care facility. She had been cared for by paid caregivers since the age of ten. It was difficult for her to ambulate independently and she wore braces on both legs to improve her stability.

On the day in question she had been given a hair permanent in the kitchen and was taken to the bathroom to rinse her hair.

Her caregiver left her standing alone in the bathroom without her leg braces only for a moment and she fell backward into the bathtub and broke her neck.

Then staff lifted her out of the bathtub without waiting for trained paramedics from the ambulance that was on its way.

The actual cause of death was never pinned down, that is, the fall or being handled incorrectly with a broken neck.

It was, however, not disputed she was not wearing her leg braces which normally stabilized her while she stood and she was momentarily left unattended.

Fall Care Plan Was Ambiguous

Her care plan did not expressly call for her not to stand up or attempt ambulation without the leg braces even though she was prescribed her leg braces because she had a history of falling.

The facility's lawyers were going to argue that the facility staff member committed no negligence because the care plan was not violated by leaving her alone, unattended, without her leg braces.

The family's lawyers, on the other hand, were going to argue that a substandard fall-care plan is substandard care.

The case was settled for $65,000 before trial that would have taken place in the Circuit Court, Oakland County, Michigan. **Williams v. Valley Residential Service, Inc., 2007 WL 2439303 (Cir. Ct., Oakland Co., Michigan, April 25, 2007).**

Bowel Obstruction: Nurses Advocated For Pediatric Patient, Physicians To Pay Settlement.

A medical malpractice lawsuit filed in the Superior Court, Los Angeles County, California, resulted in a $8,600,000 settlement to be paid by a hospital and several physicians' medical practice groups.

The settlement was reported with a stipulation that the names of the patient, the hospital and the physicians remain confidential.

Nurse as Patient's Advocate

The hospital's director of nursing had taken over the role of the child/patient's advocate, prompting the physicians to act and orchestrating her care, by the time a complex series of events had resulted in emergency surgery in the hospital, according to the condensed statement of the facts of the case submitted by the lawyers.

The story began to unfold when the twenty-eight month-old child's mother took her to her pediatrician's office because she was vomiting.

A history of a bowel obstruction at age two weeks which required surgery and several subsequent non-surgical hospitalizations was referenced in the notes jotted down by the physician's assistant. He gave the mother Reglan and Pedialyte for the child and told her to take her to the ER if she did not improve.

The mother had to take the child to the ER just after midnight and again the next morning. At 9:00 a.m. a radiologist came in for routine review of the previous night's ER x-rays. He saw dilated loops of bowel on the child's 6:00 p.m. film the ER physician apparently missed. He had the clerk on duty fill out a form for the files describing a discrepancy between his and the ER physician's interpretation of the patient's films.

He also called the ER and spoke to the ER physician on duty, a different ER physician than the one from the night before. The ER physician/director called and left a message on the mother's answering machine and the hospital mailed her a registered letter.

Patient Admitted to the Hospital

The mother was not able to follow up with her pediatrician because the day after she got the message from the ER was Saturday and the office was closed.

Sunday afternoon she had to take the child back to the hospital. A different ER physician got an x-ray which he correctly interpreted as showing an obstruction of the small bowel. He had her admitted to the pediatric acute-care unit.

Hospital Nursing Assessment, Advocacy

On admission the nurses saw that the child's abdomen was distended and measured the circumference as 52.5 cm. Vital signs were normal.

The pediatrician came in and saw the child. He found generalized abdominal tenderness and decreased bowel sounds. A nasogastric tube was ordered.

The nurses noted at 8:40 p.m. that the NG tube was draining green bile. The abdominal circumference increased to 56.5 cm and there were no bowel sounds. By midnight the NG tube secretions had changed to brown and the BP was elevated.

At 2:15 a.m. the nurse called the physician to report the NG secretions were dark brown-black and foul smelling. The physician did not convey any new orders.

The nurses continued to monitor the child through the night until the pediatrician came in at 6:15 a.m. and called a surgeon to come in and operate. The nurses reported the child was rapidly deteriorating but the surgeon just reassured them he was his way. Within minutes the nurses began repeatedly phoning the ER physician, concerned the child was about to code.

The director of nursing became involved by personally contacting an anesthesiologist to come on board so that the child's surgery could finally begin, albeit too late to do anything about extensive necrotic tissue found within the intestines. **Confidential v. Confidential, 2007 WL 2389560 (Sup. Ct. Los Angeles Co., California, July 26, 2007).**

Dehydration: Jury Faults Nursing Facility For Patient's Death.

When he was admitted to the nursing home the elderly patient suffered from heart problems, diabetes and peripheral vascular disease.

Twice he was sent from the nursing home to the hospital. Both times the hospital found pressure sores and evidence of dehydration. He did not go back to the nursing home after his second trip to the hospital; he died in the hospital. The treating physician listed dehydration as the cause of death on his death certificate.

Nursing Documentation Input / Output

The family's attorneys could put together a strong case of negligence just from the contents of the patient's chart from the nursing home.

Fluid output far exceeded fluid input in the ten days leading up to his second hospitalization.

If he really was getting enough to drink, as the facility's lawyers argued, then that fact should have been properly charted, the family's lawyers argued.

The family's lawyers made a compelling argument to the jury that a care facility has a fundamental responsibility to provide water to drink to a basically helpless person like the deceased.

The family's lawyers also pointed out that inadequate hydration, coupled with his pre-existing peripheral vascular disease and his diabetes would only tend to worsen his problems with skin integrity.

The spotty nature of the progress charting in his chart reportedly created a general impression the patient was not getting his caregivers' full attention.

The jury in the Circuit Court, Danville City, Virginia awarded $850,000. **Musgrove v. Medical Facilities of America, 2007 WL 2614655 (Sup. Ct. City of Danville, Virginia, June 18, 2007).**

IM Injection: Court Accepts Nurse's Expert Opinion.

The patient sued an outpatient medical facility over an intramuscular Depo-Medrol injection she claimed caused nerve damage in her shoulder.

The Court of Appeals of Georgia has so far only put to rest the preliminary legal issue whether a registered nurse's report, as opposed to a physician's report, will suffice as the expert opinion a patient must file with the court to go ahead with a malpractice case.

The court endorsed the nurse's report in all respects, that is, the nurse was ruled qualified to express and opinion as to the legal standard of care for a nurse giving an IM injection and to express a medical opinion that a brachial plexus injury is a possible consequence of giving an IM injection improperly in the upper arm. **Allen v. Family Medical Center, P.C. __ S.E. 2d __, 2007 WL 2631882 (Ga. App., September 12, 2007).**

Prior to administering an IM injection the nurse must decide the most appropriate location, that is, the deltoid or the gluteal muscle.

The nurse should take into consideration the patient's age, weight, skin turgor and the type of medication to be administered.

The nurse must establish the location of the deltoid muscle, not just "eyeball" its location.

The nurse must take into consideration the patient's arm size, whether skinny, average or obese, the select the appropriate size for the needle.

An injection into the deltoid of an adult patient should be administered at a ninety-degree angle at a location approximately two inches below the acromial process, at a depth shallow enough not to contact the major brachial nerve plexuses in the patient's upper arm.

COURT OF APPEALS OF GEORGIA
September 12, 2007

Home Health: Nurse Can Sue For Dog Bite.

A home health nurse was bit on the hand while making a visit to two homebound clients who owned a Rhodesian Ridgeback, also known as an "African Lion Dog," a breed of dogs known to have vicious personalities.

The nurse sued her clients for damages. The laceration from the dog bite severed the digital nerve in her hand, required surgery and left her with residual loss of sensation in her thumb. Her medical bills totaled $14,040 and were paid by worker's compensation.

The legal rule is the owner of a breed of dog known to have vicious propensities is legally liable if the dog attacks a visitor who has been invited to visit the home. With more docile breeds of animals, the individual animal must first demonstrate that it has a hostile disposition, and the owner must fail to take appropriate precautions, before the owner can be held liable.

The jury in the Superior Court, St. Joseph County, Indiana awarded $50,000 of which the nurse must reimburse worker's compensation for $17,104 she received as benefits for her injury. **Tidey v. Holmes, 2007 WL 2640658 (Sup. Ct. St. Joseph Co., Indiana, June 13, 2007).**

Whistleblower: Court Discusses CNA's Rights.

A resident assistant in an adult foster care facility claimed she repeatedly reported to her charge nurse that a resident had a wound on his bottom that was not healing and that she continued to see blood in his underwear.

She was told to use Gold Bond powder, which did not seem to work.

After leaving work one day the aide phoned the state department of social services. A state investigation followed. The report of the state investigation said there was no problem with the particular resident's care and he himself reported to investigators he did not feel his care was being neglected.

The investigators did cite the facility for three violations, two involving the administrator's qualifications and a third relating to medical records issues.

When the aide's supervisor figured out she was the one who filed the report she did not do anything except put in her file a positive evaluation she had already completed. The aide took time off for a medical leave, another person was called in to do her job and the aide was laid off when her physician let her return to work.

A healthcare employee absolutely cannot suffer employer reprisals for reporting to proper authorities what the employee realistically believes to be abuse or neglect of a vulnerable patient.

UNITED STATES DISTRICT COURT
MICHIGAN
September 4, 2007

The US District Court for the Eastern District of Michigan reiterated the strong legal protection the law affords to whistleblowers but found the evidence inconclusive in this case that the aide was laid off in retaliation for her report to social services. **Taylor v. Alterra Healthcare, 2007 WL 2571978 (E.D. Mich., September 4, 2007).**

Race Discrimination: Facility's Nurses Were Not Treated Differently Based On Race.

An African-American nurse was employed as restorative nursing coordinator in a nursing and rehabilitative center.

Her promotion to charge nurse was about to begin when she was abruptly terminated over several months backlog of uncompleted "paperwork" left over from her coordinator position.

She sued for race discrimination. The US District Court for the Eastern District of Pennsylvania pointed to several factors that required the court to dismiss her case.

There was no evidence of racial animosity at the facility such as racial remarks toward her or about her or about other minority employees. Most of the employees at the facility were African-American.

Similar Non-Minority Employee Needed As Basis for Comparison

She said two Caucasian nurses got more favorable treatment but the court said their situations were not the same.

One Caucasian nurse twice falsified patients' charts, but she was also fired, albeit only after a state survey revealed the problem. Another Caucasian, a charge nurse, was permitted to work overtime to complete her charting. However, a charge nurse's first priority is caring for patients and supervising direct patient care. A care coordinator's job, on the other hand, involves only administrative functions like care planning and program management, with no direct patient care responsibilities, and does not justify overtime compensation to "get caught up with paperwork," the court believed. **Williams v. Bala Retirement and Nursing Center, 2007 WL 2571526 (E.D. Pa., August 31, 2007).**

To establish a case of race discrimination, an employee must belong to a minority group, suffer some sort of adverse employment action and be able to show he or she was treated differently, that is, less favorably than a non-minority in the same circumstances.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
August 31, 2007

Nurse Spills Hot Coffee On Newborn Infant: Jury Finds Nurse, Facility Negligent.

A jury in the Superior Court, Maricopa County, Arizona awarded a verdict of $7,000 for a newborn infant scalded by hot coffee spilled on him by a nurse.

The jury heard arguments the nurse was negligent for bringing an open hot-beverage container into the newborn nursery.

The jury also heard arguments that the hospital was negligent for not establishing and enforcing a policy prohibiting caregivers from bringing open hot-beverage containers into patient care areas and anywhere near the newborns.

The jury awarded damages only to compensate the baby for the injury, not to compensate the parents for emotional distress and no punitive damages. **Snyder v. Arrowhead Community Hosp., 2007 WL 2592401 (Sup. Ct. Maricopa Co, Arizona, January 16, 2007).**

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For the Nursing Profession

Failure To Diagnose Stomach Cancer: Nurse Practitioner Partly To Blame.

A thirty-seven year-old wife and mother of three children died from stomach cancer.

Her widower and children sued the outpatient gastroenterology clinic where she had been seen for chronic abdominal complaints. They were awarded $500,000 from the clinic by a jury in the Superior Court, Pierce County, Washington for medical and nursing malpractice.

Korean was the patient's first language. The clinic's nurse practitioner was faulted for not overcoming the language barrier.

The nurse practitioner got the erroneous impression and charted that the patient was not taking her Prevacid when in fact she was. Persistence of her symptoms with the Prevacid would have prompted a physician to do an endoscopy which probably would have caught the cancer. **Kim v. Priebe, 2007 WL 2415592 (Sup. Ct. Pierce Co., Washington, April 30, 2007).**

Nurse's Abusive Response To Call Bell: Termination Ruled Justified.

The Court of Appeals of Minnesota ruled that a long-term care facility had legal grounds to terminate a registered nurse for failing to respond appropriately to a resident's call bell.

The nurse had a history of verbal abuse of vulnerable residents and had already been through mandatory retraining before the incident in question.

A resident rang her call bell at night for assistance to go to the restroom. The nurse replied in a harsh tone over the intercom that she was turning off the resident's call light and she better not turn it on again. When she finally got to the room the nurse made an insulting remark about the resident being overly demanding of attention.

With or without her record, this one incident was grounds for termination, the court ruled. **Swift v. Evangelical Lutheran Good Samaritan Society, 2007 WL 2472347 (Minn. App., September 4, 2007).**

Skin Breakdown: Facility Hit With Substantial Judgment For Poor Nursing Care, Documentation.

The Supreme Court of Mississippi approved a $1,000,000 judgment against a nursing home after a resident died with a six by ten inch decubitus ulcer on her coccyx. The judgment was reduced to $500,000 under Mississippi's cap on damages against public healthcare facilities.

Immobile patients who are susceptible to skin breakdown must be turned every two hours as a preventative measure before skin lesions develop, according to the nursing experts whose testimony was endorsed by the court.

This resident's chart showed she was turned only at three to eight-hour intervals, below the standard of care for pressure relief in vulnerable patients. She apparently was not turned often enough even after decubitus started.

Nutrition is essential in the maintenance of skin integrity, especially in older people who are immobile.

Poor nutrition can contribute to the development of a decubitus ulcer.

Nurses need to encourage patients to eat, perhaps by substituting more attractive foods like ice cream which can boost caloric intake.

Patients also need to be turned every two hours.

SUPREME COURT OF MISSISSIPPI
September 13, 2007

She remained in one position for more than sixteen hours, which was right before her lesion progressed to Stage III, according to her chart.

Good nutrition is also essential. A resident's refusal to eat must be addressed. Antidepressant medications are a recognized appetite stimulant for geriatric patients, the court said.

Good hydration is also essential for skin integrity. Daily fluid intake of 2,000 to 3,000 cc's should be provided and documented in the chart, the experts testified in this case.

If a pressure sore starts, which may not necessarily be the facility's fault, the facility must provide and document acceptable wound care. **Delta Reg. Med. Ctr. v. Venton, __ So. 2d __, 2007 WL 2670302 (Miss., September 13, 2007).**