LEGAL EAGLE EYE NEWSLETTER

October 2008 — *For the Nursing Profession* — Volume 16 Number 10

Opioid Analgesic, Respiratory Depression: Court Upholds Nursing Negligence Lawsuit.

The Court of Appeals of Texas ruled the parents had grounds to sue the hospital and eight nurses named individually in the lawsuit for the death of their sixteen year-old daughter.

Sequence of Events

The patient was seen in her primary care physician's office for fever, cough, congestion and chest pain.

Two days later her mother took her to the hospital emergency room for coughing, cramping, vomiting, weakness and dizziness. She was admitted to acute care on a medical/surgical floor.

The patient's condition worsened significantly over the next twenty four hours.

Her records revealed that on the evening of her second day in the hospital her oxygen saturation dropped to 81% fifteen minutes after the nurses gave a fourth IV dose of the opioid analgesic Stadol.

An O_2 sat that low was especially problematic, in the opinion of one of the parents' medical experts, a physician board-certified in internal medicine and pulmonology who also held a professorship at the University of Texas School of Nursing, because the patient was already on supplemental O_2 from a nasal cannula. The nurses switched her to a non-rebreathing oxygen mask.

The patient's condition deteriorated for more than twenty four hours before she arrested and could not be revived.

The nurses continued the IV Stadol while her oxygen saturation dropped perilously low even though she was on supplemental oxygen.

The patient died from a cardiac arrhythmia secondary to hypoxia.

COURT OF APPEALS OF TEXAS
September 25, 2008

At noon the next day the nurses discovered they could not wake her to have her cough, phoned the treating physician and notified the house nursing supervisor.

The patient was promptly given CPR and intubated, but she died while being wheeled to the ICU. The post-mortem exam pointed to bacterial myocarditis creating a susceptibility to arrhythmia from hypoxia.

Nursing Negligence

The parents' expert opined in his court deposition that clinical criteria for intubation existed twenty-four hours before the final series of events.

The nurses were faulted for failing to appreciate the danger of respiratory depression in this patient, failing to monitor the patient for signs of such depression, for continuing an opioid medication in the face of obvious signs of respiratory depression, failing to communicate the patient's condition to the treating physician or an available physician and for failing to advocate for review or discontinuance of the medication, intubation or other timely and appropriate medical intervention.

Reportedly the nursing progress notes used the word "hypoxia" to describe what was going on, but other than switching the oxygen mask nothing was done about it until it was too late. **Wise Regional Health Systems v. Brittain, __ S.W. 3d __, 2008 WL 4354710 (Tex. App., September 25, 2008).**

Inside this month's issue ...

October 2008

New Subscriptions
See Page 3

Epidural Morphine: Wrongful Death Lawsuit Faults Early Discharge From The Hospital.

The forty-nine year-old male patient was sent home from the hospital the same evening after umbilical hernia repair, abdominoplasty and liposuction.

He suffered a fat embolism that night and died at home. His family sued the surgeon, the certified registered nurse anesthetist, two staff nurses and the hospital.

The family's lawyers then dropped the surgeon and staff nurses from the lawsuit, electing for tactical reasons to focus squarely on the nurse anesthetist's decision to send the patient home prematurely.

The Court of Appeals of Texas ruled that the expert witness's opinion the family's lawyers filed with the court in support of the family's wrongful-death lawsuit contained a correct statement of the legal standard of care.

Post Epidural Morphine
24 Hour Monitoring Required
In a Skilled Setting

The patient received an epidural consisting of lidocaine, Marcaine, fentanyl and Duramorph. According to the expert's opinion endorsed by the court, these medications in combination are appropriate for epidural administration for elective abdominal surgery.

The patient's intra-operative and immediate post-operative course were unremarkable.

The problem came from discharging the patient home that evening when he should have been kept in the hospital for close observation.

The court pointed to the fact the manufacturer's standard package-insert warnings for epidural use of Duramorph require 24-hour post-operative skilled monitoring of the patient, that is, the patient needs to be kept in an inpatient setting where trained personnel can watch for common and uncommon complications and side effects and have the equipment, facilities and specialized medical care available at hand to deal with complications. **Renaissance Surgical Centers v. Jimenez, 2008 WL 3971096 (Tex. App., August 28, 2008).**

Under no circumstances should a patient be allowed to go home from the hospital the same day the patient receives epidural morphine.

If this patient had been kept in the hospital, trained medical personnel would most likely have picked up on the signs and symptoms of a fat embolism following his liposuction, abdominoplasty and umbilical hernia repair.

The manufacturer's warning for epidural administration of Duramorph, a trade name for preservative-free morphine sulfate, says that the patient must be monitored in a skilled setting for at least 24 hours post-operatively.

A skilled setting could be an intensive care unit, telemetry unit or a regular medical/surgical nursing floor.

The basic necessity is that the skilled setting have the personnel and equipment to handle complications and side effects that can arise after epidural morphine is used.

Complications can commonly include respiratory depression, pruritis, nausea, vomiting and sedation.

COURT OF APPEALS OF TEXAS
August 28, 2008

Fecal Impaction: Lapses In Care Lead To Settlement.

The eighty-three year-old resident had been in the long-term care facility fifteen years, thirteen in assisted living and her last two on a nursing floor.

After she died in the hospital the coroner's exam revealed signs of long-standing constipation and fecal impaction.

Even though her chart records from long-term care seemed to show she was eating well and having regular bowel movements until the very end, her probate estate's wrongful-death lawsuit alleged she was not getting proper attention and care.

The estate's lawsuit was settled, reportedly soon after the judge in the Circuit Court, Miami-Dade County, Florida ruled he would allow evidence to go to the jury that certain chart entries were fabricated after the fact and would allow punitive damages if the jury believed that was true.

The judge ruled he was going to let the jury consider awarding punitive damages.

It came to light the medical records were altered after the fact.

The patient supposedly was cared for for two more days after she had already died in the hospital.

The assessments and care charted at the end were completely inconsistent with the coroner's post-mortem.

CIRCUIT COURT
MIAMI-DADE COUNTY, FLORIDA
August 5, 2008

Paradoxically, the resident had willed half her sizeable fortune to the nursing facility, which agreed in the settlement to accept $600,000 less than the total it was to inherit. **Estate of Beedle v. East Ridge Retirement Village, 2008 WL 4210677 (Cir. Ct. Miami-Dade Co., Florida, August 5, 2008).**

Alzheimer's: Elopement Leads To Large Verdict For Wrongful Death.

Before entrusting their eighty-seven year-old family member to the facility's care the family met with the nursing facility's administrator to stress the importance of security and to obtain his assurances that secure care was available and would be provided.

However, soon after the resident was admitted staff started letting him keep his cigarettes and go outside unsupervised to smoke, contrary to the assurances that were given to the family, according to the evidence reportedly revealed in court.

One day he wandered away. He was struck by a truck and killed in an intersection five miles from the facility.

The jury in the Superior Court, Los Angeles County, California awarded the family $1,480,000 from the facility. The verdict included compensation for the family's loss as well as punitive damages for recklessness, consumer fraud and elder abuse. **Wilson v. Son, 2008 WL 4223607 (Sup. Ct. Los Angeles Co., California, May 27, 2008).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924
© 2008 Legal Eagle Eye Newsletter

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

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

E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
PO Box 4592
Seattle, WA 98194–0592
Phone (206) 440-5860
Fax (206) 440-5862
kensnyder@nursinglaw.com
www.nursinglaw.com

Patient Abuse: Aide Found Guilty Of Misappropriation Of Property.

Misappropriation of a resident's property means the deliberate misplacement, exploitation or wrongful temporary or permanent use of a resident's belongings or money without the resident's consent.

A CNA who is experienced in the care of dementia patients knows that despite their normal appearances they do not have the wherewithal knowingly to give others the use of their property.

The CNA also knew that at this facility the residents who had phones in their rooms were billed separately for their phones on monthly invoices that itemized the charges for each outgoing call, local or long distance.

The resident was only billed $1.73 for nine calls by the CNA, but the size of the bill is beside the point.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
September 4, 2008

The family of a long-term dementia patient became concerned and contacted management at the nursing facility when they received a bill for outgoing telephone charges.

Families had the option of paying extra for a phone in the room and receiving itemized statements for outgoing calls, local or long distance. Many residents did not have phones. This resident was not up to the task of making calls herself, but the family got her a phone anyway so that they would be able to call her.

It came to light that a CNA made the calls from the resident's phone, nine calls over three days, to her next door neighbor's home and adult daughter's cell phone numbers. The charges totaled $1.73.

The CNA was reported to the state department of health, was found guilty of misappropriation of a resident's property and was listed in the state registry of persons found guilty of abuse. The Superior Court of New Jersey, Appellate Division, turned down the CNA's appeal and upheld the department's actions.

It was irrelevant that the CNA had permission from the resident. The court labeled that argument "ingenuous." The CNA knew the resident was not capable of making a knowing decision.

The size of the bill was also irrelevant. The point was that the CNA had taken what was not hers and should not be allowed to work with vulnerable persons. **New Jersey Dept. of Health v. Robert, 2008 WL 4066426 (N.J. App., September 4, 2008).**

Clip and mail this form. Or if you prefer order online at www.nursinglaw.com

Print $155/year _____ Online $95/year _____ Phone 1-877-985-0977

Check enclosed _____ Bill me _____ Credit card _____ Fax (206) 440-5862

Visa/MC/AmEx/Disc No. _____

Signature _____ Expiration Date _____

Name _____
Organization _____
Address _____
City/State/Zip _____
Email (If you want Online Edition*) _____

***Print subscribers also entitled to Online Edition at no extra charge.**

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

Patient Falls: No Justification For Restraints, Facility Ruled Not Liable.

The seventy-four year-old patient was brought to the E.R. by her husband for what appeared to be an anxiety attack.

The standard E.R. work-up found one of her cardiac enzymes was elevated, so the physician admitted her to the telemetry unit with an order for bed rest. A telemetry unit nurse assisted her to the restroom. Three minutes later the patient got up by herself to go again, fell and broke her hip.

There was no physician's order for restraints or for a sitter.

There was no documented justification for raising the bed rails or for any other form of restraint.

SUPERIOR COURT, MORRIS COUNTY
NEW JERSEY
August 19, 2008

The jury in the Superior Court, Morris County, New Jersey found no negligence.

The patient was in the early stages of Lewy body dementia and had been going to adult daycare three days a week.

The jury, however, accepted testimony from the hospital's medical and nursing experts that there was no discernable justification for bed rails, a vest restraint or a sitter.

Hindsight is not the standard for imposing legal liability after a patient has fallen in a healthcare facility. Caregivers' actions are judged based only on the assessment data available before the fact.

The hospital's nursing expert testified that restraints indeed were contraindicated as potentially harmful based on the patient's presenting history of a recent anxiety attack. **Ahearn v. Morristown Mem. Hosp., 2008 WL 4210683 (Sup. Ct. Morris Co., New Jersey, August 19, 2008).**

Patient Falls: Facility Ruled Not Liable Based On Nurse's Safety Inspection.

A wheelchair-bound patient fell in the bathroom of his hospital room while attempting to transfer himself from his wheelchair to the commode.

His fractured hip from the fall required surgery and a lengthy and painful period of convalescence.

His lawsuit against the hospital focused on the fact the grab bar on the wall broke loose when he put weight on it to support himself during the transfer.

An injury due to a defect in the condition of the premises cannot be the basis for a negligence lawsuit unless the owner of the premises caused the defect or was aware or at least should have been aware it.

UNITED STATES DISTRICT COURT
TENNESSEE
September 11, 2008

The US District Court for the Western District of Tennessee dismissed the lawsuit based on a documented walk-around safety check of the unit performed by a nurse just a few days before the accident.

The nurse was able to testify that her inspection targeted issues with the physical premises that could conceivably pose hazards to patient safety. She remembered specifically checking the grab bars in the patient bathrooms to make sure they seemed to be securely fastened to the wall.

The court did not go so far as to rule whether safety inspections in a hospital are primarily a nursing as opposed to a facilities-management responsibility. **Bridgeman v. US, 2008 WL 4206729 (W.D. Tenn., September 11, 2008).**

Post-Surgical Monitoring: Anoxic Brain Injury Blamed On Nursing Negligence.

The sixty year-old patient did well for three days following emergency surgery for ventral-hernia repair.

On the third day her physicians noticed problems with lung function. The medical diagnosis was not conclusive. Two possibilities were alveolar pneumonia and congestive heart failure.

After a previous surgery she had had a bout of fluid overload from congestive heart failure which resolved with diuretic therapy, so the physicians opted to start IV Lasix again this time. The pulmonologist came in in the evening and was told by the nurses that her respiratory status had markedly improved with the Lasix.

The nurses reported to the pulmonary specialist that evening that her respiratory status was much improved after the Lasix was started.

Then during the night the nurses did not closely monitor the patient or report that her respiratory status was actually deteriorating badly.

SUPERIOR COURT
SANTA CLARA COUNTY, CALIFORNIA
July 29, 2008

At 6:30 a.m. the patient went into cardiopulmonary arrest and was left with residual catastrophic brain damage.

The case filed in Santa Clara County, California settled for $3,000,000. The basic argument was that with competent nursing monitoring the physicians would have been alerted in time to intubate the patient. **Confidential v. Confidential, 2008 WL 4210698 (Sup. Ct. Santa Clara Co., California, July 29, 2008).**

Emergency Room: No Record Of Cardiac Complaints, Suit Dismissed.

The forty year-old patient had a fatal heart attack in the hospital after he was admitted for fluid replacement following a serious gastric upset at home.

The jury in the Circuit Court, Collier County, Florida ruled the hospital E.R. personnel were not guilty of negligence.

The family's attorney reportedly brought to court one of the hospital's emergency-room intake forms filled out to show complaints of cardiac symptoms.

However, it could not be substantiated that the intake form was actually filled out that day by the patient in the emergency room.

CIRCUIT COURT, COLLIER COUNTY
FLORIDA
April 1, 2008

The actual E.R. record revealed no complaints of chest pains or other indications of cardiac involvement and a thorough assessment of the patient's abdominal distress. Family members who were with him that day could not corroborate that the patient complained of chest pains when he arrived in the emergency room.

The patient reportedly first went to a different hospital but decided not to stay there because the wait was too long. At the second hospital, where he ultimately died, he told the people in the emergency room that he had just left another hospital and driven almost a half hour to get to their hospital, conduct anyone would see as inconsistent with a patient having chest pains from a heart attack. **Hughes v. Hamann, 2008 WL 4210686 (Cir. Ct. Collier Co., Florida, April 1, 2008).**

Confidentiality: Charge Nurse Is Fired, Had Copied, Removed Records For Legal Purposes.

The charge nurse copied pages from charts for more than a year and forwarded them to the director of nursing and the administrator in reference to concerns over the performance of a staff LPN whom she supervised.

She was not reprimanded or told not to copy pages from the charts. Performance review is a legitimate concern and does not violate medical confidentiality.

Later, however, in sharp contrast, the charge nurse began copying material from patients' charts for the alleged purpose of protecting herself in the event she herself was reported to the state board of nursing.

The latter records were not turned over to her superiors. The charge nurse took the copies home with her, a clear violation of the facility's policies and a violation of HIPAA as well.

The charge nurse had her own complicated history of disciplinary issues with her employer. Regardless of what else was going on, a gross breach of patients' rights confidentiality was a legitimate reason to fire her.

UNITED STATES DISTRICT COURT
OREGON
August 25, 2008

The US District Court for the District of Oregon dismissed a complex lawsuit filed by a former nursing-home charge nurse against her former employer alleging retaliation, wrongful discharge and violation of her rights under the US and Oregon family and medical leave laws.

The charge nurse's termination was the culmination of a long history of personnel disputes and disciplinary issues concerning the safety and quality of her own patient care and her nursing charting.

The court ruled, regardless of what else was going on, that the facility had grounds to terminate the charge nurse after she began photocopying and taking home with her portions of hers and other nurses' patients' medical charts allegedly for her own protection in the event she was reported to the state board of nursing.

Legitimate vs. Illegitimate Practices

The court pointed out it was perfectly legitimate for the charge nurse to copy material from charts and forward the copies to her director of nursing and the administrator as part of an ongoing evaluation of a particular staff LPN's job performance.

Quality review and performance assessment are necessary and legitimate functions that do not violate medical confidentiality as long as patients' records stay within the treating facility.

A nurse's concern for the nurse's own legal self-protection, on the other hand, is not a legitimate reason to copy any patient's confidential records.

The charge nurse only dug herself in deeper by taking the copies home with her, by maintaining her own private files and by making no effort to conceal the identities of the patients.

When patient's medical records must enter the court system to resolve legal issues that do not directly involve the patient in question, Federal law requires that all patient-identifying information must first be redacted. **Howard v. Milwaukie Conv. Hosp., 2008 WL 4117167 (D. Or., August 25, 2008).**

Family-Member Interference: Court Sees Harassment, Upholds Restraining Order.

The Court of Appeals of Minnesota agreed with the decision of the local county district court judge to issue a restraining order permanently barring a nursing-home resident's daughter from any further communication or contact with the management or staff of the nursing facility where her mother resides.

The court's decision was based on a finding that the daughter's conduct fit the legal definition of harassment.

Interference With Nursing Care

The last straw was when the daughter brought in a birthday cake for her mother to share with the other residents on her unit at the nursing facility.

As many residents had dietary restrictions or swallowing issues, the facility administrator told her it was best to let a nurse have control of giving out the cake.

The daughter, not believing what she had been told, pointed to a resident and asked an aide if the resident was diabetic. When the aide replied "yes," the aide was reprimanded by the administrator on the spot and reminded not to divulge confidential medical information. The daughter then went to the nursing station and leafed through the dietary tickets to find out for herself which residents were diabetic.

A security guard had to remove the daughter from the facility. While being bodily removed she screamed at a nurse and waved some legal-looking paperwork in the nurse's face, causing the nurse to fear for her own personal safety.

On another occasion the daughter phoned the nursing station and demanded that the nurse who answered the phone conduct an immediate review of the care plan to determine if her mother had been assisted to the restroom no later than 7:00 a.m. that morning. That was only one of a long series of repeated angry, demanding, demeaning letters and phone calls which forced management to go to court when they finally reached their breaking point.

Johnson v. Berg, 2008 WL 3897846 (Minn. App., August 26, 2008).

A family member certainly has the right to consult with caregivers, to voice his or opinions and to advocate for alternatives. However, the situation here went far beyond reasonable advocacy and became harassment.

The nursing facility is entitled to a restraining order that the resident's family member cease and desist from harassing conduct.

Harassment is defined to include repeated incidents of intrusive or unwanted acts, words or gestures that have a substantial adverse effect on the safety, security or privacy of another person.

The resident's daughter repeatedly sent harassing letters of complaint on the same subjects to the nursing facility and followed up with harassing phone calls to staff, verbally abused the administrator face-to-face on at least six occasions and personally interfered with the nursing care of other residents.

Actual fear for personal safety is not a necessary element, but if it is present it will, of course, lend support to a court's finding of harassment.

COURT OF APPEALS OF MINNESOTA
August 26, 2008

Bloodborne Pathogens: Employer Pays Travel, Time For Off-Site Medical Care.

US Occupational Safety and Health Administration (OSHA) regulations require healthcare employers to provide immunizations for caregivers who face occupational exposure to bloodborne pathogens and to provide for post-exposure medical evaluation and treatment at no cost to the employee.

The phrase "at no cost to the employee," the US Court of Appeals for the Third Circuit has ruled, means that the employer must also reimburse employees' mileage and pay them for their time as if on duty if evaluation or treatment occurs off-site or outside regular work hours.

Needlesticks – Off-Site Testing Employees' Mileage and Time are Covered

Two nurses who had needlesticks at the same nursing home filed complaints with OSHA. The nursing home agreed to foot the bill for testing and re-testing for Hep B but refused to reimburse their mileage to and from the off-site medical clinic and did not compensate them for their time.

The US Court of Appeals agreed with OSHA that OSHA, being a Federal agency, can enforce Federal occupational safety and health regulations according to OSHA's own interpretation of language in the regulations when the exact meaning of the language, as it often happens, is not crystal clear.

Although OSHA regulations do not expressly answer the question, the OSHA administrative board interpreted OSHA's regulations to include paid time and reimbursed mileage within the broader mandate that immunizations, testing and care for bloodborne-pathogen-related issues must be provided "at no cost to the employee."

Secretary of Labor v. Beverly Healthcare, __ F. 3d __, 2008 WL 4107489 (3rd Cir., September 4, 2008).

Risk Management: Court Limits Attorney-Client Privilege.

An eighty-two year-old family member of a patient fell on ice and snow in the medical facility's parking lot.

A housekeeper happened to look out the window and saw him on the ground. The housekeeper told the nursing supervisor on duty and quickly went out to the parking lot to help the man.

The nursing supervisor also went out to help him and right afterward filled out an incident report for risk management. Risk management, sensing that a lawsuit was in the offing, referred the matter to outside legal counsel. The outside legal firm sent in an attorney to interview the nursing supervisor and the housekeeper.

Does the Nursing Supervisor Have To Answer Questions in a Deposition?

The issue at this point is whether the nursing supervisor must answer questions in a pre-trial deposition.

The Superior Court of Connecticut ruled she must testify. What she told the attorney will be off-limits. Simply what she saw, what she heard and what she did, however, are not off-limits, even though the same facts were put in the incident report and told to the attorney. **Adams v. Johnson Memorial Hosp., 2008 WL 4308083 (Conn. Super., September 2, 2008).**

The basic facts are proper subjects for testimony, what the nursing supervisor saw, what she did and what the man may have said.

What she told the facility's attorney is protected by the attorney-client privilege.

SUPERIOR COURT OF CONNECTICUT
September 2, 2008

Skin Care: Care Plan Was Ignored.

The patient's skilled-nursing care plan for recuperation from hip surgery included monitoring pressure areas for redness and repositioning every two hours.

Because her postural hypotension made it difficult to get her out of bed she was left lying most of the time in the same position in bed. She developed a Stage IV decubitus ulcer on her heel. The nurses ignored the complaints CNA's relayed to them of pain in her foot. Her case in the Superior Court, Butte County, California settled for $210,000. **Chapman v. Feather River Hosp., 2007 WL 5494781 (Sup. Ct. Butte Co., California, May 29, 2007).**

Prenatal Care: Lawsuit Faults Nurse Practitioner.

A lawsuit in the US District Court for the Central District of California resulted in a settlement of $470,000 awarded to the infant born with chromosomal abnormalities and $30,000 to the parents.

The twenty-nine year-old mother, pregnant with her third child, had an ultrasound at eight weeks which was normal.

She asked her nurse practitioner at least twice during her prenatal care for repeat ultrasounds. Her nurse practitioner refused, allegedly on the grounds that the state agency Medi-Cal would not pay for it.

The nurse practitioner referred her as a private-pay patient to a clinic which was in questionable status with state and Federal authorities. The ultrasound from the clinic, which reportedly was sent to the hospital but never reviewed by the nurse practitioner, showed the fetus had six fingers.

The lawsuit claimed the nurse practitioner should have done repeat ultrasounds herself and should have been alerted by the outside clinic's ultrasound to the possibility of a chromosomal abnormality and done follow-up amniocentesis testing. **Confidential v. Confidential, 2008 WL 4223605 (C.D. Cal., June 30, 2008).**

Pediatric Immunizations: New Vaccine Information Materials.

The US Centers for Disease Control and Prevention (CDC) now has available a consolidated vaccine-information statement that may be handed out for any and all of the immunizations routinely given in babies' first six months, in lieu of handing out the individual vaccine-information statements for each of the vaccines actually administered at a particular visit.

The new consolidated statement contains the CDC's current recommendations for the timing of newborns' immunizations, although those recommendations did not change from before the advent of the new consolidated vaccine-information form.

The new consolidated statement is on our website at http://www.nursinglaw.com/infantvaccines.pdf

This and other vaccine information statements are also available from the CDC on the Internet at http://www.cdc.gov/vaccines/pubs/vis

FEDERAL REGISTER August 28, 2008
Pages 50821 – 50824

Sexual Assault: Foreseeability Is The Key Issue.

During a routine room check an aide caught a dementia patient in another patient's room about to have sex with her, apparently believing she was his wife.

The US District Court for the Eastern District of Michigan ruled that a long-term care facility can be held liable in this situation only if the victim can prove the facility had reason to foresee that the perpetrator would act out this way. This man had never before wandered from his own room at night or been violent toward others. **Glanda v. Twenty Pack Mgt. Corp., 2008 WL 4058590 (E.D. Mich., August 28, 2008).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Psych: No Fall-Risk Assessment Done, Negligence Found.

The day before she fell and fractured her right tibia and fibula the fifty-seven year-old patient was involuntarily admitted to the hospital's psychiatric unit for suicidal ideation. She had been in the same hospital several times over the previous few months for the same reason.

Psychiatric Admission
No Fall-Risk Nursing Assessment

The fall-risk portion of the admission nursing assessment form was crossed out with the letters "N.A." signifying that the nurse believed that risk assessment and fall precautions are not included in psychiatric care. The same nurse's admitting progress notes pointed to unsteady gait, muscle weakness, confused mental state and poor judgment.

The patient reportedly awoke, rang for help to the restroom, got no response and got up on her own. The jury in the Supreme Court, Richmond County, New York awarded her $598,000. **Cifelli v. St. Vincent's, 2008 WL 4093163 (Sup. Ct. Richmond Co., New York, July 17, 2008).**

Neonatal Intensive Care: Nurses Faulted For Delay In Transfer.

An infant born at the hospital in the early morning hours immediately showed signs of respiratory distress.

At 3:45 a.m. the physician consulted by phone with the nearby university hospital's neonatal ICU regarding the infant's status. Personnel in the ICU said that unless they heard back otherwise they would wait to dispatch a transport team until the team came to work at their regular start time, 7:30 a.m.

The transport team got to the first hospital at 8:50 a.m. By they time they got the infant to intensive care at the university hospital permanent brain damage had already set in.

The Superior Court of Connecticut found grounds to implicate the first hospital's nurses along with the physician for negligence for failing to see the dire need and for failing to advocate for immediate transport. **Nelson v. Dettmer, 2008 WL 3916245 (Conn. Super., July 30, 2008).**

Smoking: Unattended Patient Dies From Burns, Lawsuit Focuses On Patient Safety Assessment.

The elderly stroke patient had been admitted to the nursing facility for respite care for two weeks twice each year for thirteen years, then on a permanent basis after his wife could no longer care for him at home.

An aide left him alone in the smoking room. When the aide looked in again minutes later the patient was fully engulfed in flames. He was extinguished but died within minutes.

The US District Court for the District of Columbia ruled it was a question for the jury to decide if this patient was properly assessed and should or should not have been allowed to smoke.

The family's nursing expert was prepared to interpret Joint Commission standards and other survey-research studies to require assessment of the patient's mental acuity, physical limitations and equipment issues in determining whether the patient should be allowed to smoke at all and whether stand-by supervision is more appropriate than full independence.

The facility's medical director was ready to point out that the patient had full use of his right hand and arm and had conscientiously followed the rules more than a year for smoking only in the designated area, although he did have little use of his left arm and hand, had a history of seizures and had mild cognitive impairments. He was not considered a high-risk smoker as he knew the smoking rules and was thought to be able to self-manage in the event of a fire. **Sanders v. US, __ F. Supp. 2d __, 2008 WL 3903458 (D.D.C., August 26, 2008).**

There is a national consensus that patients who are going to smoke must be assessed for their ability to smoke safely.

This patient had little use of his left hand, was prone to seizures and was cognitively impaired.

However, he did have full use of his right hand and arm and had been consistently following the rules.

UNITED STATES DISTRICT COURT
DISTRICT OF COLUMBIA
August 26, 2008