LEGAL EAGLE EYE NEWSLETTER

October 2009 *For the Nursing Profession* Volume 17 Number 10

Disability Discrimination: Hospital Is Not Required To Allow Service Animal To Stay.

The US District Court for the District of Oregon agreed with the patient that she is a person with a disability for purposes of the Americans With Disabilities Act (ADA).

A hospital is a place of public accommodation which is required by the ADA to make reasonable accommodation to a patient's disability.

What Is Reasonable?

The question was just how reasonable it was for the hospital to accommodate the patient's insistence that her service animal, a large dog, remain with her at her bedside 24/7.

Her dog helps her by retrieving dropped objects, getting her crutches and by steadying her when she transfers from sitting to standing.

The patient has been an inpatient at the hospital for several days to a week for complications of multiple sclerosis on more than one hundred occasions over the last dozen years.

Her dog was with her in the hospital the last twenty-nine times before the hospital informed her she would be refused readmission the next time if she brought her dog with her.

The court ruled the hospital was not guilty of disability discrimination and issued an injunction against her bringing this or any other animal with her to the hospital in the future.

A hospital must keep all of its patients safe, must provide all of its patients with quality health care and must assure that all of its employees have a safe place to work.

What this particular patient saw as less than equal treatment was the hospital's attempt to accommodate not just her but other patients, visitors and staff as well.

UNITED STATES DISTRICT COURT
OREGON
August 31, 2009

Problems With This Service Animal In A Hospital Setting

The dog smelled bad. The hospital had to transfer certain patients off the floor because they could not tolerate the odor. It took at least a day to clean and deodorize the rooms afterward.

Hospital aides had trouble stepping over the animal even to serve meals to the roommate, not to mention the safety hazard if there was an emergency.

Hospital staff had to escort the dog outside several times a day to urinate and defecate. Some hospital staff were allergic to the dog and had to be reassigned to different units.

Finally, the physician epidemiologist connected with the hospital's infection-control department obtained confirmation from the dog's veterinarian that the dog had infections which were wholly inappropriate in a sanitary healthcare setting.

Hospital administrators felt compelled to sue for an injunction. In turn, the patient counter-sued for disability discrimination. In defining the word "reasonable" in the phrase "reasonable accommodation" the court ruled that the needs of other hospital patients, staff and visitors, on balance, outweighed this patient's attachment to her animal. **"Jane Roe" v. Providence Health System, __ F. Supp. 2d __, 2009 WL 2882947 (D. Or., August 31, 2009).**

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Parkinson's: Nursing Home Resident Did Not Receive Her Meds On Time.

The downward spiral in an eighty-one year-old nursing home resident's health that led to her death allegedly could be traced to neglect by the nursing staff to see to it that she got her Parkinson's medication on schedule.

Before entering the nursing home her Parkinson's was reportedly well controlled with her medication and she had no prior history of skin breakdown.

She started not eating and not taking in fluids as she should have.

She started losing weight, became incontinent and developed a urinary tract infection.

Skin breakdown started on her buttocks and progressed to a Stage III decubitus, with MRSA involvement, that had to be debrided in the hospital.

Then she was sent to a hospice where she passed.

SUPERIOR COURT
DURHAM COUNTY, NORTH CAROLINA
May 1, 2009

The family filed suit in the Superior Court, Durham County, North Carolina.

The nursing home was prepared to argue that the patient had already reached end-stage Parkinson's before she was admitted to the facility and that the outcome was basically inevitable even with the best possible nursing assessment and care.

The nursing home nevertheless agreed to pay a pre-trial settlement of $380,000 to the beneficiaries of the patient's probate estate. **Confidential v. Confidential, 2009 WL 2501820 (Sup. Ct. Durham Co., North Carolina, May 1, 2009).**

Central Venous Catheter: Nurses Failed To Verify Placement.

A diabetic developmentally-disabled adult patient was admitted to the hospital's intensive care unit with a diagnosis of neuroleptic malignant syndrome.

A hospital resident decided to start a venous catheter in the patient's right leg, but reportedly inserted the catheter into the femoral artery rather than the femoral vein.

Various medications including vasoconstrictors were given through the catheter before the error was discovered. Blood clotting led to ischemia which led to tissue necrosis which eventually required amputation of the leg.

The nurses should have recognized that he catheter was placed incorrectly in the femoral artery rather than the femoral vein.

The nurses should have examined the catheter for arterial back-flow.

After determining that the catheter was misplaced the nurses should have taped it off to alert other nurses not to use it, should have alerted the medical staff and should have documented the situation in their nursing progress notes.

CIRCUIT COURT
OAKLAND COUNTY, MICHIGAN
June 18, 2009

The hospital reportedly argued there was no proof the incorrect placement caused the patient's arterial occlusion

Nevertheless the hospital agreed to a $2,100,000 settlement on behalf of the resident physician and the nurses in the patient's lawsuit filed in the Circuit Court, Oakland County, Michigan. **Hamdan v. Bell, 2009 WL 2828000 (Cir. Ct., Oakland Co., Michigan, June 18, 2009).**

Perioperative Nursing: Nurse Must Inspect Instrument Handed Back.

To start the arthroscopic knee surgery the surgeon used a scalpel to create two instrument portals through the skin.

The blade was missing when the surgeon handed the scalpel handle back to the scrub nurse.

Not until almost the end of the case was the missing blade noticed and reported to the surgeon by a surgical tech who had started cleaning up.

The surgeon got an x-ray which confirmed the blade was still inside. It broke apart when the surgeon reopened one portal incision and tried to pull it out with forceps. By then the tourniquet had been restricting blood flow too long, so the surgeon opted to wait until later to open up the knee to remove the blade fragments.

The apparently defective scalpel handle was discarded by the scrub nurse at the conclusion of the case.

The hospital cannot argue that a surgical nurse is not negligent who fails to notice that a scalpel handed back to her by the surgeon is missing its blade.

COURT OF APPEALS OF WASHINGTON
September 14, 2009

The Court of Appeals of Washington ruled there were grounds for a negligence lawsuit against the surgeon and against the hospital as the scrub nurse's employer.

In the hospital's favor, the court ruled there was no indication the scrub nurse was guilty of spoliation of the evidence. The court was satisfied the nurse tossed the scalpel handle simply because it was defective and could not be used again. The court detected no motive to get rid of legally adverse evidence. Doing that could have been separate grounds for a lawsuit. **Ripley v. Lanzer, __ P. 3d __, 2009 WL 2915689 (Wash. App., September 14, 2009).**

Refractive Schizophrenia: Court Faults Nurse Practitioner's Care Of Outpatient Psych Patient.

The forty-eight year-old patient had a history of fifteen to twenty mental health hospitalizations over a period of thirty years.

When he moved from California to Washington State he began treating with a nurse practitioner in a community mental health clinic.

The nurse practitioner's assessment was that he clearly had a thought disorder and residual psychotic symptoms and behaved like a chronic schizophrenic. She decided to continue the clozapine he was taking along with Depakote to control the seizures, a side effect of the clozapine, to which he had been prone. She explained the purpose of the medications to him and the need for compliance.

A social worker took over as his case manager. Over time she was able to gathered from him that he was only taking his clozapine for a few days before his blood tests and was basically non-compliant. She advised him it was dangerous to do that.

The client moved back to California. When he presented at the clinic in his old hometown the psychiatrist conferred with the nurse practitioner in Washington State and on the nurse practitioner's recommendation changed his medication to Zyprexa.

Then he moved back to Washington.

The patient's experts are prepared to testify that the patient's correct psychiatric diagnosis is refractive paranoid schizophrenia.

The accepted treatment for refractive schizophrenia is the medication clozapine.

Clozapine carries with it an appreciable risk of seizure if the patient is not also put on Depakote.

Medication compliance has to be monitored. The practitioner must continue asking the patient if he is taking his meds, his clozapine as well as his Depakote. Beyond that, periodic blood tests are necessary to verify therapeutic levels of plasma clozapine.

If a family member reports medication non-compliance or signs of seizure, involuntary commitment must be seriously considered as the only realistic option.

COURT OF APPEALS OF WASHINGTON
September 14, 2009

The nurse practitioner decided not to continue the clozapine since the client was going on and off it anyway. She renewed the Zyprexa from California.

The client started hearing voices and decompensating in his ability to care for himself. He was briefly put on Risperdal and Depakote during an emergency hospitalization at an acute-care facility.

His case manager saw him getting more paranoid and delusional. She reported to the nurse practitioner he was obviously off his medications. His apartment manager called and told the nurse practitioner he found him lying in the middle of his living room hallucinating. His sister also called to express her grave concern.

His sister went out and found him convulsing on the floor of his apartment. Physicians at the hospital believed he had been convulsing for days and soon would have died if the sister had not found him.

He now suffers from renal failure and has permanent traumatic brain damage from the prolonged seizure.

The Court of Appeals of Washington agreed with the patient's medical experts that pushing for clozapine with close self-reporting and laboratory compliance monitoring was the only effective treatment for his refractive paranoid schizophrenia, along with Depakote for his seizures.

His symptom escalation and decompensation after he decided no longer to take the clozapine and Depakote pointed to the need for the nurse practitioner to initiate involuntary treatment proceedings. **Jacobs v. Compass Health, 2009 WL 2938630 (Wash. App., September 14, 2009).**

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Pregnancy Discrimination: Court Finds Unequal Treatment, Nurse Has Grounds For Her Case.

While she was out on maternity leave an LPN began receiving calls from the facility's LPN supervisor and from the RN supervisor trying to get her to come back to work sooner than planned.

They reportedly threatened that if she did not return to work right away, once she did return she would be fired if she missed even a single day. They also held over her head the issue whether she would be given a choice between a.m. or p.m. shift if she did not cut her maternity leave short.

Medication Error Leads To Termination

The LPN refused to be threatened and took her full maternity leave, only to be fired over a medication error shortly after she did come back to work. The US District Court for the Eastern District of Arkansas went over the details very carefully.

She gave Atarax to a patient for whom Vistaril was ordered. Although those are trade names for two basically equivalent drugs she was not sure how to chart it in the medication administration record. She eventually went back and made a note for each night for more than a week that she did, in fact, give Atarax, but without noting it as a "late entry" as required by facility policy. Then she had to go back again and cross out her entries for two nights she later realized she did not actually work.

The LPN admitted that what she did was a clear violation of nursing standards and of facility policies and procedures.

However, for purposes of anti-discrimination law that was only part of the story. A male LPN had committed a medication error which could have compromised a resident's safety and then compounded his error by falsifying his charting after the fact to try to hide what he did.

What the male LPN did was at least as serious or even more serious that what the female LPN in question did, yet the male was only suspended for three days.

The court ruled that preferential treatment given to a male co-worker created a *prima facie* case that this female LPN was a victim of pregnancy discrimination. **Griffin v. Webb, __ F. Supp. 2d __, 2009 WL 2870526 (E.D. Ark., September 3, 2009).**

A male LPN was not fired, only suspended for three days, after he neglected to give a resident her medication, then gave the medication late but did not notify the physician and then falsified the medication administration record.

The terminated female LPN in question has a pregnancy discrimination case.

One of the fundamentals of anti-discrimination law is that an employee with a certain characteristic who claims to be a victim of discrimination must demonstrate that at least one other employee who lacks that characteristic was treated more favorably.

This applies across the board in race, gender, nationality, disability and pregnancy discrimination.

In general, to prove discrimination an employee must prove:

The employee is in a protected group;

The employee is meeting the employer's legitimate expectations;

The employee was the victim of adverse action; and

Another employee, not in the protected group, was treated more favorably.

UNITED STATES DISTRICT COURT
ARKANSAS
September 3, 2009

Disability Discrimination: No One Knew Aide's HIV Status.

An aide was terminated from her position in a nursing home after an incident in which she raised her voice at an elderly dementia patient and then refused to leave the room when a supervisor asked her to leave so that the agitated resident could calm down.

The aide sued for disability discrimination based upon her positive HIV status.

The US District Court for the Eastern District of New York dismissed her case.

Unknown Disability Employer Did Not Discriminate

HIV+ status is recognized as a disability for purposes of disability discrimination law. However, in the hiring process employers are prohibited from inquiring about prospective employees' disabilities. This facility never asked her and the aide never told anyone. Her HIV status was in her file at the last healthcare facility where she worked, but there was no proof that her prior employer ever relayed that confidential information to this employer.

Second, even if her supervisors did know about her disability, mistreatment of a vulnerable resident would be considered a legitimate, non-discriminatory reason for disciplining or terminating an aide. **Volmar v. Cold Spring Hills Center, 2009 WL 2984194 (E.D.N.Y., September 14, 2009).**

No Post-Injury Accommodation.

An LVN was terminated from her job on the IV team shortly after returning to work after neck surgery. She sued for disability discrimination, alleging she was denied reasonable accommodation.

The judge in the Superior Court, Los Angeles County, California ruled the hospital had legitimate, non-discriminatory grounds to terminate her because she had agreed when hired two years earlier to get her RN and to complete training to insert central venous catheter lines, but never did either. **Plum v. Children's Hosp., 2009 WL 2989401 (Sup. Ct. Los Angeles Co., California, April 28, 2009).**

Freedom Of Speech: Nurse's Task-Force Testimony Is Protected.

A staff nurse employed by the Washington State Department of Corrections was terminated after his letters to public officials about prison health conditions resulted in him being called to testify before a Department risk-management task force. The nurse sued the Department for retaliation and violation of his Constitutional right to Freedom of Speech.

There is no question the nurse's testimony to the Department of Corrections risk management task force and the letters he wrote to various public officials are free speech protected by the First Amendment.

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT
June 18, 2009

The US Court of Appeals for the Ninth Circuit ruled the nurse is entitled to his day in court to try to prove his case. He has to prove that the upper-level decision-makers who fired him knew that he wrote letters to public officials and testified to the task force. If they knew that the nurse is entitled to an inference in his favor that retaliation was their motivation.

The former health care manager of the prison where he worked apparently had no knowledge of his letters or his testimony before she was told to fire the nurse. Her dismissal from the case will stand.

Subject of Public Concern

Freedom of Speech only applies to subjects of public concern. Communicating with co-workers on mundane day-to-day issues by oral, written or electronic means is a regular part of a nurse's job, is not a subject of public concern and cannot qualify as a basis for a retaliation lawsuit. **Dalton v. Wash. Dept. of Corrections, 2009 WL 1974260 (9th Cir., June 18, 2009).**

"English-Only" Rule: Hispanic Caregivers Awarded Settlement In Class-Action Lawsuit.

US Equal Employment Opportunity Commission Regulations
"Speak-English-Only Rules"

(a) *When applied at all times.* A rule requiring employees to speak only English at all times in the workplace is a burdensome term and condition of employment. The primary language of an individual is often an essential national origin characteristic. Prohibiting employees at all times, in the workplace, from speaking their primary language or the language they speak most comfortably, disadvantages an individual's employment opportunities on the basis of national origin. It may also create an atmosphere of inferiority, isolation and intimidation based on national origin which could result in a discriminatory working environment.

(b) *When applied only at certain times.* An employer may have a rule requiring that employees speak only in English at certain times where the employer can show that the rule is justified by business necessity.

(c) *Notice of the rule*. It is common for individuals whose primary language is not English to inadvertently change from speaking English to speaking their primary language. Therefore, if an employer believes it has a business necessity for a speak-English-only rule at certain times, the employer should inform its employees of the general circumstances when speaking only in English is required and of the consequences of violating the rule. If an employer fails to effectively notify its employees of the rule and makes an adverse employment decision against an individual based on a violation of the rule, the Commission will consider the employer's application of the rule as evidence of discrimination on the basis of national origin.

Selection Procedures

The Commission will carefully investigate employment selection procedures involving fluency in English requirements, such as denying employment opportunities because of a foreign accent or inability to communicate well in English.

The US Equal Employment Commission (EEOC) filed a national-origin discrimination lawsuit in the US District Court for the Central District of California on behalf of fifty-three Hispanic employees of seventeen nursing facilities.

The lawsuit resulted in monetary compensation totaling $450,000.

The facilities also entered into an agreement with the EEOC to protect their Hispanic employees from future discrimination, to provide them with opportunities for English-language proficiency training and to institute in-service training for supervisors and managers as to their obligations under US Civil Rights laws.

English-Only Rules
National Origin Discrimination

In a nutshell, it is unlawful national-origin discrimination to prohibit employees from conversing with one another in a native language other than English. This includes on-the-job communication as well as communications while off duty, going and coming, on break, etc.

Business Necessity

Business necessity is an acceptable justification for an employer to require employees to have proficiency in English and to speak only in English, according to the EEOC guidelines.

Business necessity includes verbal communication which is necessary for the job with other employees who do not speak the employee's native language.

For example, the courts have ruled a hospital is permitted to have a rule expecting housekeepers who do not have English as their first language to be able to speak to and to receive instructions from nurses who do not speak their language. The rationale is that effective communication is essential to the hospital's patients' safety and wellbeing.

Business necessity also includes the ability to communicate with members of the public not fluent in the employee's native language, but only if dealing with the public is a necessary part of the employee's job. **EEOC v. Royal Wood Care Ctr. et al., 2009 WL 2569472 (C.D. Cal., April 9, 2009).**

Home Health: Caregivers Are Not Responsible For Elopement After Lapse In Client's Regular Daily Routine.

The contract with the family expressly stipulated that an aide was to come to the home for one hour between 11:30 a.m. and 12:30 p.m. every day, Monday through Friday, to do light housekeeping and to fix the client's lunch.

The family hired the home health agency because their eighty-five year-old father was showing signs of dementia. Unfortunately the severity of his illness was not fully appreciated until his last elopement, which resulted in injuries and, in turn, a lawsuit against the home health agency.

Break In Regular Daily Routine Client Went Looking For Caregiver

One day the agency aide showed up an hour late. The client was gone. Later that afternoon a neighbor called the son and told him his father was crawling around on the neighbor's lawn with his face bloodied from a fall in which he had broken his jaw.

Adult Protective Services investigated. They determined the gentleman needed a secure dementia-care placement. It came to light he had, in fact, wandered away from home twice before.

Home Health Agency Did Not Take Responsibility For Dementia Care

The Court of Appeals of Washington said that the family's home-health experts' assessment of the situation was probably correct.

Strict daily routine is extremely important to dementia patients. This gentleman became upset when his caregiver did not show up on time him and left the home to find someone to help him.

However, the experts' assessment was beside the point, legally speaking. The home health agency contracted only for one hour of daily non-licensed care.

The agency never took on responsibility for providing supervision and security to prevent elopement. Agency staff had no authority or even the means to keep the gentleman from leaving his home. The agency is not liable. **Robins v. Home Care of Washington, 2009 WL 2883386 (Wash. App., September 10, 2009).**

The client's need for around-the-clock supervision in a secure dementia-care facility was painfully obvious after the fact.

That need, however, went far beyond what a one-hour daily time commitment from a home health agency could fulfill.

The home health agency is guilty of breach of contract, at worst.

The family has no grounds to sue the home health agency for negligence for the client's injuries from his fall during his elopement.

The home health agency did not assume the responsibility to prevent the client from eloping from his own home.

The agency had no legal obligation, no legal authority, not to mention no realistic way to physically restrain the client in his home if he wanted to leave, no matter how unsafe it was for him to wander away.

It is not necessary to find fault with the family for failing to appreciate the patient's needs. The only issue is that the home health agency never agreed to provide full dementia care.

COURT OF APPEALS OF WASHINGTON
September 10, 2009

Resident Not Restrained, Falls: Out Of Court Settlement Paid.

The eighty-two year-old nursing home resident was injured in two falls six weeks apart. In both instances staff reportedly neglected to lock the wheels of her wheelchair.

In the first incident the resident pushed herself away from the dining table and tried to stand up. In the second incident she was left unattended in the day room, again with her wheels not locked, and fell when she tried to stand up.

That she was prone to falling was a fact reportedly passed along by the family when she was admitted. She was assessed with a gait abnormality and vascular dementia and arguably should have been considered a high-fall-risk patient.

A seatbelt restraint and a seat alarm were indicated for the patient in addition to surveillance that her wheels were locked, the patient's lawyer was prepared to argue.

The nursing home's insurance company reportedly paid a $150,000 out-of-court settlement. **Cebollero v. Hebrew Home, 2009 WL 2989743 (Westchester Co., New York, March 16, 2009).**

Choking: Patient Required Close Supervision For Impulse Disorder.

The patient was brain damaged from a diabetic coma as a young man.

His diet was carbohydrate controlled for dysphagia with close supervision while eating and with stand-by suction available.

All of his special care parameters were seemingly being met at the nursing home but one night he grabbed a half-eaten sandwich off the meal cart, stuffed it in his mouth, suffocated and died. The Court of Appeals of Kansas ruled it was not within the common knowledge of lay persons that the standard of care was violated. **Tudor v. Wheatland Nursing, __ P. 3d __, 2009 WL 2834786 (Kan. App., September 4, 2009).**

Child Abuse: Mother's Suit Against Hospital Thrown Out.

Hospitals, physicians and nurses are on the list of caregivers who are mandatory reporters of signs of child abuse. They have no choice.

Cocaine in a newborn's system is considered a sign of child abuse which triggers the legal duty of a mandatory reporter to file a report.

Hospital staff notified local child protective services when a newborn's blood test was positive for cocaine.

Shortly after discharge from the hospital, child protective services went out and removed the infant from the home. The mother sued hospital personnel for conspiring to violate her Constitutional rights.

The courts are beginning to recognize the integrity of the family unit as a Constitutional right.

UNITED STATES DISTRICT COURT
MISSISSIPPI
September 8, 2009

The United States District Court for the Southern District of Mississippi acknowledged that integrity of the family relationship is gaining legal recognition as a Constitutional right. The mother's case was not completely frivolous.

However, for the time being, it is very clear that mandatory reporters of child abuse have legal immunity from lawsuits in civil court for carrying out their mandatory legal responsibilities in good faith.

The court pointed out the mother was given the opportunity to tell her side of the story in a court hearing a few days after her child was taken away from her.

Although it was not up to her caregivers at the hospital to guarantee or to deny her the right to a fair hearing, the fact that she got a fair hearing tended to negate the idea that anyone was trying to deprive the mother of her rights, the court said. **Stewart v. Jackson County, 2009 WL 2922940 (S.D. Miss., September 8, 2009).**

Withdrawal From Alcohol: IV Na Monitored, No Liability Found.

The fifty-six year-old patient, reportedly an alcoholic, came to the hospital's emergency room for detoxification.

Blood tests in the E.R. disclosed a serum sodium of only 101 mEq/L so she was admitted for gradual IV sodium replenishment.

Two days later the patient's serum sodium increased by 8 mEq/L between blood draws, so the internist stopped the sodium IV.

The patient developed central pontine myelinolysis, a brainstem injury which has left her in a coma. She was transferred to an extended-care facility.

The jury in the Supreme Court, Orange County, New York found no fault with the patient's caregivers. The jury apparently accepted the hospital's experts' testimony that IV sodium replenishment was indicated and that the necessarily gradual rate of replenishment was appropriately monitored. **Estate of Beck v. Pine, 2009 WL 2998251 (Sup. Ct. Orange Co., New York, June 16, 2009).**

Fall: No Assist, Settlement Paid.

An eighty-seven year-old resident fell while getting off the bus that had transported her and other residents to a museum outing.

She fractured both bones in her lower right leg and had contusions to her head and jaw. Blunt force trauma to her lungs led to bronchopneumonia from which she died seventeen days later.

No one was assisting her at the moment she fell, despite the fact she was known to have difficulty ambulating.

The nursing home paid $175,000 to settle the family's lawsuit filed in the Supreme Court, Kings County, New York. **Estate of Falsone v. River Manor, 2009 WL 2998278 (Sup. Ct. Kings Co., New York, May 4, 2009).**

Withdrawal From Alcohol: Nurses' Care Faulted, Ignored Cardiac Issues.

The patient checked into the hospital's substance abuse recovery center with a blood alcohol of .224 after reportedly drinking four quarts of liquor in the preceding seventy-two hours.

The nurses obtained orders over the phone from a physician for Valium for withdrawal symptoms as well as an EKG and blood work.

The EKG reportedly showed signs of cardiac arrhythmia and the lab work showed signs of electrolyte imbalance.

These abnormalities were apparently not communicated to the physician and no effort was made to hydrate the patient intravenously to bring his electrolytes back into balance.

Nor was a cardiologist brought in to look at the EKG and provide critical input about the patient's cardiac issues.

The hospital was dropped from the wrongful death lawsuit for a $75,000 settlement before the jury in the Circuit Court, Cook County, Illinois returned a verdict of $300,000 against the physician and his medical practice group. **Langer v. Holy Family Med. Ctr., 2009 WL 2993913 (Cir. Ct. Cook Co., Illinois, May 15, 2009).**

Morphine Pump: Faulty Refill.

The patient had a surgically-implanted pump for a morphine and bupivacaine mixture for chronic pain.

A home health nurse reportedly injected the medication directly into the patient rather than the pump reservoir, then refused to call an ambulance until the patient had passed out.

The patient received a $6,000 verdict from a jury in the Circuit Court, Allen County, Indiana for allegedly inadequate training of the nurse. **Anderson v. Elkhart Gen. Hosp., 2009 WL 2436794 (Cir. Ct. Allen Co., Indiana, March 19, 2009).**

Legal Eagle Eye Newsletter
For the Nursing Profession

Sexual Abuse: One Aide Can Be Disciplined Based On Another Aide's Hearsay Testimony.

The aide was supplied on a temporary contract basis by a staffing agency to work in a nursing home.

Accusations that the aide sexually abused an elderly resident were upheld by the Court of Appeals of Utah. His name is now in the state registry of persons who are permanently barred from care-giving employment with vulnerable persons.

Aide Objected to Hearsay Testimony Objection Overruled

As a general rule, hearsay cannot be used in a criminal prosecution or in an administrative proceeding which could affect a person's ability to purse his or her livelihood in a major way.

That is, the resident herself was never called to testify. The case against the male aide was based on testimony from a female aide, a regular facility employee who had worked with the resident before and whom the resident trusted.

The female aide testified in graphic detail what the resident told her about an hour after it happened, the things the male aide did to her after he took her into the bathroom over her protests she did not want to be helped by a man.

"Excited Utterance" Exception to the Hearsay Rule

A so-called "excited utterance" is an exception to the general rule that hearsay is not admissible in court, the court said.

An excited utterance occurs when a person blurts out something right after a startling or unusual event, while the person is still feeling excitement, stress or distress from the event and the utterance pertains to the startling event.

The law's rationale is that spontaneity while excited or under stress or distress tends to negate the likelihood of fabrication.

Corroboration Was Available

The female aide reported the allegations immediately to her superiors. The facility promptly investigated and reported to the state.

The resident's statements to a nurse, a social worker, the director of nursing and a state investigator, also hearsay, were completely consistent with what she told the female aide at the very start. The resident was also not acquainted with the male aide before this incident and had no reason to harbor animosity, except for what he did to her that evening. **Benitez v. Dept. of Health, 2009 WL 2902518 (Utah. App., September 11, 2009).**

Breast Cancer: Clinic Nurse Shares The Blame For Delayed Diagnosis, Patient's Untimely Death.

The husband, as executor of his deceased wife's estate, sued the women's health clinic, the clinic nurse, her supervising physician and the radiologist who read a mammogram and a sonogram.

The suit filed in the Supreme Court, Queens County, New York alleged that timely diagnosis could have saved his late wife's life. By the time she finally had a mastectomy most of the dissected lymph nodes were positive for cancer which had metastasized.

The sums agreed to be paid by way of settlement allocated fault 16% to the clinic nurse, 15% to her physician supervisor and approximately 60% to the radiologist who apparently misread the mammogram and the sonogram that were done on referrals from the clinic nurse.

The estate's lawyers argued that the clinic nurse should have referred the patient for a biopsy and/or evaluation by a surgeon.

The patient still complained about the lump and she and the nurse could both tell it was growing.

The nurse should have presumed it was cancer notwithstanding the negative mammogram and sonogram.

SUPREME COURT
QUEENS COUNTY, NEW YORK
March 10, 2009

Cancer Presumed Until Ruled Out By Biopsy

Had the case not settled, the husband's lawyers were prepared to argue that the clinic nurse should have referred her patient for a biopsy, a definitive method to rule out cancer, when the patient continued to complain about the lump in her breast, notwithstanding the negative mammogram.

As the lump progressed to what would be characterized as a mass rather than a lump, which the patient and the nurse could both tell was growing, the nurse should not have relied upon the negative sonogram report, but should have referred the patient for a biopsy and/or evaluation by a breast surgeon, the husband's experts were prepared to say. **Estate of Jones v. Lefkowitz, 2009 WL 2998241 (Sup. Ct. Queens Co., New York, March 10, 2009).**