LEGAL EAGLE EYE NEWSLETTER

October 2010 *For the Nursing Profession* Volume 18 Number 10

Dehydration: Nursing Interventions Could Have Saved Patient, Lawsuit To Go Forward.

After hospitalization for a stroke the patient was transferred to a nursing home for rehabilitation.

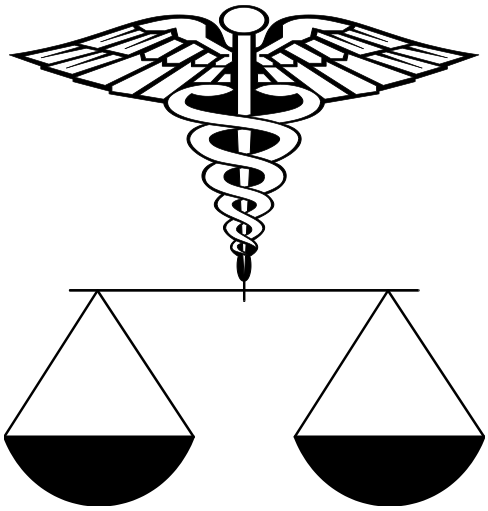
Soon the patient began suffering from chronic diarrhea which resulted in her death from dehydration less that three months later. The daughter, as personal representative of her late mother's estate, sued the nursing home and the treating physician for negligence resulting in her mother's wrongful death. The Court of Appeals of Ohio ruled there were grounds for the lawsuit to go forward.

The experts hired by the family's lawyers to testify against the nursing home stated that the patient's death was caused by dehydration due to prolonged diarrhea caused by the patient's continued use of the diabetes medication metformin and a diuretic prescribed for her high blood pressure, as well as substandard care.

Substandard Nursing Care

The nurses failed to record the patient's daily bowel movements. That would have provided a basis for informing her doctor that her diarrhea had been going on for months.

The nurses failed to monitor, document and report that her weight was steadily declining even though she was eating well. She was not being weighed on a daily or even weekly basis.



The patient's death could have been prevented by various interventions as late as a few days before her death.

These interventions include discontinuing her diabetes medication metformin which is known to cause diarrhea, treating her diarrhea and rehydrating her with intravenous fluids or increasing the fluids she was taking by mouth.

COURT OF APPEALS OF OHIO
June 30, 2010

The patient's blood pressure was not being monitored even though she was on medication for high blood pressure. Her blood pressure once dropped so low that she actually collapsed.

More than one month before her death there was a nursing note the patient had poor skin turgor, an obvious sign of dehydration, but there was no documentation of further assessment or follow up.

According to the family's experts, a medical doctor and an RN who was also a licensed nursing home administrator, it is standard practice in a nursing home to carefully monitor and document possible signs and symptoms of dehydration as well as to monitor and record the patient's daily fluid intake, but that was not done.

The patient's death would have been prevented, the family's medical expert went on to say, if the nurses had reported the diarrhea and dehydration to the doctor and discussed discontinuing the metformin. The nurses should also have increased the fluids the patient was getting by obtaining an order for an IV and/or increasing the fluids she was getting orally. The basic cause of death was substandard nursing and medical care, the Court concluded. **Sliwinski v. Village at St. Edward, 2010 WL 2622936 (Ohio App., June 30, 2010).**

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Decubitus: Court Endorses Nursing Expert's Statement Of The Standard Of Care.

After she passed, the elderly patient's probate estate sued the hospital where she was treated for a spinal infarct and the nursing home where she went later.

The estate's lawsuit focused on the alleged inadequacy of the patient's skin assessments and care leading to a Stage II and later Stage IV sacral decubitus and a second lesion on her right heel.

As a first line of defense the hospital's and nursing home's lawyers argued the technical point that the estate's nursing and medical experts' preliminary reports did not correctly state the standard of care for the patient's nurses in the hospital and nursing home settings. The Court of Appeals of Texas disagreed and has allowed the estate's lawsuit to remain pending.

Skin Care - Hospital Setting
Standard of Care

The standard of care requires the hospital and its nursing staff to provide the necessary care and treatment to prevent the development of pressure ulcers.

The standard of care requires that there be a regular documented scheduled turning and repositioning program for the patient. Every two hours the patient should be turned and each and every turn documented and the position in which the patient was placed should be noted.

Standard of Care Not Followed

There was no regularly scheduled documented repositioning schedule in the patient's medical records.

Only occasional or periodic notations that the patient was turned and repositioned could be gleaned from the chart.

Multiple entries were found in the chart that the patient was being encouraged to stay off her back, but were are a similar number of notations that the patient was almost always found lying flat on her back.

The patient was taught how to position herself to decrease pressure on her back but, again, there were multiple notations that the patient was forgetting to roll on her side as she was taught. To expect a patient who is confused to remember to roll on her sides is unrealistic and below the standard of care, the family's experts said.

This patient, in fact, was basically paraplegic from her spinal infarct and was not able to use her legs and could not reposition herself even if she had the presence of mind to try to do so.

Since the patient was almost always ending up flat on her back, wedges, pillows and other methods were appropriate to maintain her in one or the other side-lying position to relieve the pressure on her sacral area.

The patient's nurses also were faulted for the fact that pain control was not being addressed during the dressing changes for her wound which was being managed by the hospital's physical therapy department.

Skin Care - Nursing Home Setting
Standard of Care

First off, a nursing facility should not accept a patient if the facility is not able to meet the patient's needs for skin care, dietary management, medical management and pain control. A patient with a Stage IV lesion who is forgetful needs a high level of assistance with nutrition, hydration and mobility in addition to care focused directly on her skin condition.

Standard of Care Not Followed

Records from the nursing home contained only six total entries of the patient being turned and repositioned over a twenty-two day period, and those reportedly were noted to be "for comfort" despite the patient's ongoing need for such care every two hours for pressure relief.

As in the hospital, the nursing home nurses also did not pay attention to the patient's need for pain control in connection with her dressing changes and physical therapy sessions.

Pain control should have been planned in advance and routinely provided.

Wrongful Death
Allegations Thrown Out

Although the patient suffered greatly during her last days, the Court was not convinced her death was itself caused by the skin lesions. The Court dismissed that facet of the estate's lawsuit. **Christus Spohn v. Lackey, 2010 WL 3279706 (Tex. App., August 19, 2010).**

Documentation: Pain To Be Noted As Reported By The Patient.

According to the Court of Appeals of Minnesota, it is misconduct serious enough to justify termination for a nurse to document the severity of the patient's pain without asking the patient himself or herself to verbalize a subjective rating of his or her pain.

In documenting the patient's pain, it is for the patient, not the nurse, to assign a number on a scale of 1 to 10 if a 1 to 10 numerical scale for pain documentation is the formula in use at the hospital. **Johnson v. Allina Health System, 2010 WL 3463640 (Minn. App., September 7, 2010).**

Elopement: Civil Monetary Penalty Upheld.

The ninety-two year-old nursing home resident had a history of wandering. The nursing facility was aware of that and had a care plan that called for keeping the resident where she could be seen and frequently checking to see that she was still present and accounted for.

After the resident wandered away alone and was discovered some time later walking along a highway, the US Court of Appeals for the Fifth Circuit was not willing to overturn a one-time $5,000 civil monetary penalty imposed on the facility.

The facility claimed that a contractor hired to replace the door-alarm system had turned off the existing system while preparing to install a new system and never told anyone the system was turned off.

Assuming that did happen, the facility still did not fulfill its obligation under Federal regulations to provide adequate supervision and assistance to ensure that the resident's environment remained as free of accident hazards as reasonably possible, the Court said. **Clear Lake Nursing Home v. US Dept. of Health & Human Services, __ F. 3d __, 2010 WL 3528833 (5th Cir., September 13, 2010).**

Lithium Toxicity: Court Faults Nurse Practitioner.

The patient's psychiatric nurse practitioner at the community mental health clinic heard reports from persons at the patient's assisted living placement that suggested she was having lithium toxicity.

The nurse practitioner sent the patient to the lab for a blood draw with an express order for a lithium level.

However, the nurse practitioner never followed up by getting and reviewing the lab results or by ordering additional testing, according to the judge in the US District Court for the District of Alaska.

Moreover, according to the judge, by the time she was sent for this blood draw it had been over eight months since her last lithium level check, too long for a patient on lithium to go without a routine lithium level, with or without signs or symptoms of possible toxicity.

The patient went into cardiac arrest and is now on a ventilator, which the Court ruled was the direct result of negligence by the psychiatric nurse practitioner, the staff at the assisted living home and the lab where the patient was sent for her lithium blood draw.

$1,000,000 in damages were awarded plus future medical expenses. **Liebsack v US, 2010 WL 3522342 (D. Alaska, September 2, 2010).**

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Fall: Jury Says Nurses Were Not Negligent, No Damages Awarded.

The family's lawsuit alleged that the patient lay on the floor after she fell until 7:00 a.m. the next morning without being discovered by the hospital's nurses.

The hospital chart, however, contained a nurse's note that the patient's son was phoned at 1:05 p.m. and informed that his mother had fallen five minutes earlier at 1:00 p.m. that same afternoon. He was not first notified at 7:00 a.m. the next morning as he insisted in court.

The patient did not need a bed alarm, bed side rails or a sitter at her residential placement prior to coming to the hospital.

Hospital policy is to order a bedside sitter only when the patient is belligerent, hostile or overly anxious, none of which described this patient.

CIRCUIT COURT
OAKLAND COUNTY, MICHIGAN
September 18, 2009

The ninety year-old Alzheimer's patient had to be brought to the hospital by her son from an adult foster care facility after she began showing signs of a possible stroke, that is, a new facial drop and drooling. She also had a urinary tract infection.

The son told the emergency room staff that his mother had no recent history of falling.

Nevertheless, the first nurse assigned to the patient on the med/surg floor where she was sent made note she was raising the side rails, lowering the bed and providing a call light as fall-risk precautions.

The hospital chart contained nursing documentation that the patient was turned and repositioned every two hours and was checked on frequently between turnings.

Experts testified for the hospital that a bed alarm was not indicated for this patient, and, in any event, would not have prevented her from falling.

Phone records from the hospital corroborated the nursing documentation that a nurse phoned and spoke with the patient's son within minutes after his mother fell. His mother did not lay on the floor in her room all night until 7:00 the next a.m. without being discovered by the nurses.

Despite the fact the patient did fall in her hospital room and did sustain injuries, the jury in the Circuit Court, Oakland County, Michigan reportedly deliberated only forty-five minutes before returning a verdict finding that the patient's nursing care was appropriate in all respects. **Heffernan v. William Beaumont Hosp., 2009 WL 6836584 (Cir. Ct. Oakland Co., Michigan, September 18, 2009).**

Nutrition: Facility Did Not Notify Physician, Family Of Change In Condition, Civil Monetary Penalty Upheld.

A resident of a skilled nursing facility, diagnosed with diabetes, dementia and depression, was dependent on others for feeding and even had difficulty swallowing pureed foods and thick liquids.

Recognized to be at risk for malnutrition, his food and fluid intake were to be monitored and recorded daily and he was to be spoon fed his meals and given nutritional supplements.

His weight dropped 18.5 pounds over five weeks. He became unresponsive and was in respiratory distress. He was taken to the hospital, having lost another 6.5 pounds, where he died. Only when he had to be taken to the hospital were the physician and the family finally notified.

Federal regulations require a nursing facility to inform the resident's physician, legal representative and family when there is a significant change in the resident's physical, mental or psychosocial status.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
June 25, 2010

Rapid weight loss in a patient at risk for malnutrition is a significant change in health status which must, by law, be reported to a resident's physician, legal representative and family.

The US Court of Appeals for the Sixth Circuit upheld a civil monetary penalty imposed by state survey inspectors on the facility for non-compliance with Federal standards which posed a risk of immediate jeopardy. **Claiborne-Hughes Health v. Sebelius, 609 F. 3d 839 (6th Cir., June 25, 2010).**

Hydration: Facility Did Not See That Resident's Needs Were Met, Civil Monetary Penalty Upheld.

A resident of a skilled nursing facility had been placed on the Focused Hydration List for increased fluid intake because she had a urinary tract infection.

Survey inspectors found, however, no documentation that even her baseline daily need for 1500 cc was being met.

Federal regulations require a nursing facility to provide each resident with sufficient fluid intake to maintain proper hydration and health.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
June 25, 2010

The facility's policy was for the night nursing supervisor to calculate each resident's daily fluid intake to determine hydration level and compare it with the resident's needs, but that was not being done.

Survey inspectors found no documentation of fluid intake in the charts of twenty of the facility's twenty-two residents.

There was an apparent overall lack of awareness among the facility's staff of the importance of adequate hydration and the importance of accurately recording fluid intake to monitor whether residents were getting adequate hydration.

In turn, there was no daily tally being kept of the resident in question's fluid intake because there was no documentation from which to make the calculation.

According to the US Court of Appeals for the Sixth Circuit, a nursing facility is not required to adopt any particular method, but must follow some method from which it can be ascertained that fluid intake is being monitored, charted and assessed in light of the patient's needs. **Claiborne-Hughes Health v. Sebelius, 609 F. 3d 839 (6th Cir., June 25, 2010).**

Hydration: Facility Pays Settlement For Death From Renal Failure, Sepsis.

The eighty-two year-old patient was admitted to s skilled nursing facility to receive IV antibiotics for a urinary tract infection.

Three weeks later she had to be transferred to an acute care hospital. She was in renal failure and was suffering from sepsis. She died six days later.

The family's lawsuit against the skilled nursing facility alleged that there was inadequate attention to the patient's intake and output of fluid despite the importance of adequate hydration to her recovery and her high risk for dehydration.

The patient's risk for dehydration was compounded, it was alleged, because she was receiving Sinequan, Ambien and Valium which reportedly were administered to her on numerous occasions without obtaining specific consent for use of psychotropic medications from her daughter who was named as her surrogate healthcare decision maker in her power of attorney.

Lack of adequate hydration prevented proper profusion of the bowels, which led to ischemic colitis, it was alleged.

Close monitoring of input and output would have identified her need for more fluids, the family's experts were prepared to testify.

SUPERIOR COURT
ORANGE COUNTY, CALIFORNIA
July 10, 2010

The family accepted a pre-trial settlement of $850,000 and agreed to drop the lawsuit filed by the administrator of the patient's probate estate in the Superior Court, Orange County, California. **Eagle v. ACME Skilled Nursing, 2010 WL 3625186 (Sup. Ct. Orange Co., California, July 10, 2010).**

Attendance Problems: Court Turns Down Nurse's Disability Discrimination Lawsuit.

The hospital's attendance policy stated that:

To provide quality care and service to our patients, residents, members and customers, employees are expected to be at their work area on time, for their regular work schedule.

The hospital recognizes, however, that employees may need time away from work for a variety of personal reasons. Time off requested and approved in advance allows for replacement planning and reduces or eliminates negative impact on productivity, coworker or department operations.

Unplanned or unreported absences, including tardiness or partial day absences, may result in disciplinary action up to and including termination.

Employees are expected not to exceed five (5) occurrences of unscheduled, unapproved absences or tardy events in a rolling twelve (12) month period.

Unplanned absences related to family medical leave, military leave, work-related illness or injury, jury duty, bereavement leave and other approved bases are not counted as occurrences under this policy.

Nurse's Disability
Fibromyalgia

The US District Court for the District of Oregon noted for the record that fibromyalgia causes chronic diffuse muscle pain and tenderness that results in fatigue and sleeplessness and may cause difficulties with concentration, standing, lifting and pushing.

There is no definitive diagnostic procedure or laboratory test for fibromyalgia. The patient's physician must rely on the patient's subjective reports of pain. However, the subjective aspect of the diagnosis does not mean that a condition does not qualify as a legitimate disability under the Americans With Disabilities Act.

Over the years the nurse received positive reviews in all aspects of her performance aside from her attendance issues. Those issues led to corrective plans as she began to exceed the hospital's upper limit for absences not approved in advance.

She requested part-time status and was given part-time status, but even that did not work out and she was eventually terminated.

The hospital is entitled to judgment in its favor.

Because the nurse was not able to live up to the hospital's attendance expectations for her job, she is not a qualified individual with a disability.

That is, the nurse's job description as a neonatal nurse clearly stated that her regular presence at the hospital was essential, and she was not able to perform that one very essential function of her job notwithstanding her disability.

Greater flexibility than the hospital allowed her coworkers would have been unduly burdensome for the hospital.

An accommodation to an employee's disability which is unduly burdensome and imposes a hardship on the employer's business operations is not a reasonable accommodation, even if the employee in question has genuine proof of a legitimate disability.

The courts give wide latitude to the employer's judgment as to the essential functions of the job and usually look to the job description that existed for the employee's job before questions came up about the employee's disability.

UNITED STATES DISTRICT COURT
OREGON
August 23, 2010

In her disability discrimination lawsuit against the hospital both sides agreed that the only problem with her performance was her attendance and that that problem was directly related to her fibromyalgia.

Disability Discrimination
Legal Standard

Employers are prohibited by law from discriminating against a qualified individual with a disability. A qualified individual is one who, with or without reasonable accommodation, can perform the essential functions of the employment position the individual holds or desires.

A disability is a physical or mental impairment that substantially limits one or more of the major life activities of the individual. In this case the nurse's fibromyalgia affected her ability to sleep and the insomnia detrimentally affected her ability to function in waking life.

The Court was willing to accept the fact the nurse had a legitimate disability. That being said, however, the Court was not willing to accept the argument that she was a qualified individual with a disability.

The Court agreed with the hospital that regular attendance is an essential function of a neonatal intensive care nurse's job in a hospital.

A hospital's mission requires it to provide nursing care to patients in need of regular and immediate medical care. Sporadic and unpredictable absences by nursing personnel interfere with the hospital's basic practice of requiring employees to follow regular schedules of attendance.

It is especially burdensome for a hospital to alter that general practice, given that the predictability of a certain level of staffing being present in the hospital is essential for proper patient care, the Court went on to state.

A hospital is not required to tolerate frequent, unplanned, unpredictable absences by a direct patient-care nursing employee, even if those absences can be related to a genuine condition which fits the legal definition of a legal disability.

In this case the hospital was granted summary judgment dismissing the nurse's lawsuit. **Samper v. Providence St. Vincent, 2010 WL 3326723 (D. Or., August 23, 2010).**

Fall: Assisted Living Facility Found Guilty Of Negligence.

The eighty-three year-old patient fell at home and had to be hospitalized. While in the hospital he suffered a stroke which left him partially paralyzed on his left side.

The effects of the stroke created major problems for him with ambulation and also seemed to have affected his short-term memory.

Before discharge from the hospital the hospital's physical and occupational therapy departments recommended for his placement following discharge that he be given stand-by assistance with ambulation.

No Assessment on Admission To Assisted Living

When the patient was transferred to an assisted living facility the nurses reportedly just assumed he was a fully independent self-care patient, without examining, assessing or evaluating him and without obtaining and reviewing his discharge paperwork from the hospital.

After the patient fell the first time, a day or two after arriving, no effort was made to re-assess his needs and change the care plan to include fall precautions.

Patient Fell, Dislocated Hip

The patient was housed on a wing of the facility for independent residents where only one aide was on duty during the night.

A fire started in the boiler room. It was put out quickly by the automatic sprinkler system, but the fire set off the fire alarm facility-wide and created a significant amount of smoke.

The one aide on duty assumed he was fully independent, that is, aware of the need to evacuate and capable of doing so on his own, and did not even try to help the patient out of his room.

While trying to exit on his own in response to the fire alarm and the smoke which was filling his room the patient fell and dislocated his hip.

The incident was the beginning of a downward spiral in his health status which the family's lawsuit alleged led to his death.

The jury in the Circuit Court, Portage County, Wisconsin awarded the family $915,397 from the assisted living facility.

Turner v. North Haven, 2010 WL 3603994 (Cir. Ct. Portage Co., Wisconsin, May 3, 2010).

The patient was admitted to the assisted living facility without a complete nursing assessment after being in the hospital for a broken hip and a stroke.

He was partially paralyzed on one side and had significant problems with short-term memory.

The physical and occupational therapists in the hospital had recommended stand-by assistance for any and all movements.

The patient was not examined, assessed or evaluated by the facility's nurses on admission.

Nor was any effort made to obtain his records from the hospital where he came from, even though the discharge recommendations would have been particularly important.

The patient was simply assumed to be independent in ambulation and in need of no assistance for routine activities of daily living.

The patient fell only a day or two after entering the facility.

That incident did not lead to review and modification of his care plan. Nor was his physician contacted for input as to his care needs and recommendations for fall precautions.

CIRCUIT COURT
PORTAGE COUNTY, WISCONSIN
May 3, 2010

Fall: Nursing Facility Found Liable.

The seventy-eight year-old dementia patient reportedly fell as many as eighteen times during her stay before her family removed her from the nursing home and filed a lawsuit.

The patient's injuries from one or more of the incidents included a fractured pelvis and trauma to her elbow and hip which required surgical repair.

The family claimed in court that the patient was supposed to be assisted any time she ambulated but was routinely allowed to ambulate without assistance.

They also claimed that they were informed of eleven falls or other unexplained injuries even though eighteen such incidents actually took place and were never contacted when the most serious injury occurred, the fractured pelvis. By law the family is entitled to be notified whenever a nursing home resident is injured.

During the trial the patient's lawyers were able to get the facility's administrator to admit to over one hundred violations of various patient-care standards.

The patient's lawsuit claimed that when she ambulated the patient was supposed to be assisted by a nurse or other staff member supporting the patient holding her up by her arm.

The patient, however, was routinely permitted to ambulate without assistance.

SUPREME COURT
BRONX COUNTY, NEW YORK
June 11, 2010

The jury in the Supreme Court, Bronx County, New York awarded the patient $500,000 which included $350,000 as punitive damages for violation of the patient's rights to adequate treatment a set forth in the state's Patient's Rights Statute.

Tannen v. Hebrew Home, 2010 WL 3297162 (Sup. Ct. Bronx Co., New York, June 11, 2010).

Fall: Jury Finds Hospital Not Liable For Patient's Injuries.

The patient was in the hospital recovering after knee replacement surgery. He wore a knee immobilizer and was using a walker to aid in ambulation.

He slipped and fell in his bathroom the day after surgery, fracturing the leg and ankle on the same leg as the knee replacement.

The patient admitted the nurses had issued him non-skid footwear.

The patient was not in need of assistance and had not been told to call for assistance to use the restroom.

Right after he fell he told his nurse that he saw the water on the floor when he entered the bathroom and that he fell when he tripped on his pants, and that was noted in his chart.

The patient's statements to his nurse on the day in question contradicted what he later said in court.

COURT OF COMMON PLEAS
HAMILTON COUNTY, OHIO
June 14, 2010

The jury in the Court of Common Pleas, Hamilton County, Ohio found no fault with the patient's nurses and awarded no damages from the hospital.

Before the case went to the jury the judge threw out the patient's allegations that the hospital had negligently hired incompetent nurses and that the nurses were guilty of violations of the state Patient's Bill of Rights and the Nurse Practice Act. **Sinclair v. Mercy Hosp., 2010 WL 3638671 (Ct. Comm. Pl. Hamilton Co., Ohio, June 14, 2010).**

Fall: Jury Finds Facility Liable For Patient's Death.

The seventy-five year-old patient was discharged from the hospital to a nursing facility for rehabilitation following colon surgery.

Her nursing assessment on admission to the nursing facility was that she required extensive assistance for repositioning herself in bed as well as for transferring and maintaining personal hygiene.

Her medical assessment on admission to the nursing facility documented that she was prone to confusion, delirium, disorientation, agitation, anxiety and urinary incontinence.

Soon after being admitted to the facility the patient was left alone in her room sitting in a high-back chair with no way to call for assistance. She was later found on the floor with a fractured hip.

She was taken to the hospital and treated for congestive heart failure, colon cancer and pneumonia in addition to the fractured hip.

The death certificate, however, reportedly listed the hip fracture as a contributing cause of death.

The family's lawsuit alleged the nursing facility should have had a policy setting parameters for when it was appropriate for a newly admitted patient to be left alone sitting in a chair.

COURT OF COMMON PLEAS
CUYAHOGA COUNTY, OHIO
January 20, 2010

The jury in the Court of Common Pleas, Cuyahoga County, Ohio returned a verdict of $766,608.12 for the family.

The judge had previously ruled that the hospital where she was treated before and after her stay in the nursing home was not liable in any way and should be dismissed from the family's lawsuit. **Sessions v. Ezra Healthcare Inc., 2010 WL 3342660 (Ct. Comm. Pl. Cuyahoga Co., Ohio, January 20, 2010).**

Fall: Patient Not Restrained, Hospital Pays Settlement.

The elderly patient was sent to the hospital from a nursing facility to reinsert the PICC line they had been using to administer antibiotics. She was in the ICU for several days, then transferred to a med/surg unit.

Her assessment was that she was a high fall risk due to shortness of breath, weakness, dementia and confusion. She was recognized to be basically unable to follow directions from others.

The care plan designed to meet her safety needs was to restrain her in bed with a vest restraint to keep her in bed and wrist restraints on both arms to prevent her from undoing the vest restraint.

The patient's wrist and vest restraints were not continued when a nursing assistant moved her from her hospital bed to her chair, nor was anyone assigned to sit with her and monitor her safety.

CIRCUIT COURT
WAYNE COUNTY, MICHIGAN
April 12, 2010

The patient's right humerus and right femoral neck were fractured when she fell.

A settlement of the patient's lawsuit filed in the Circuit Court, Wayne County, Michigan for $143,000 was paid to the family after she had passed.

Negligence was alleged for the fact the patient was moved to her chair without her restraints being continued and left alone without anyone in the room with her.

It was also alleged in the lawsuit that the facility's nursing caregivers should have advised the family not to leave the patient alone in her room and to let a nurse know before they left after visiting her in her room. **McDonald v. St. Mary Mercy Hosp., 2010 WL 3707402 (Cir. Ct. Wayne Co., Michigan, April 12, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

CT: No Nurse Standing By, Patient Dies From Cardiac Arrhythmia.

The forty-one year-old patient had spent five uneventful days recuperating in the hospital following gastric bypass surgery before he began having difficulty breathing. A CT scan of his lungs was ordered.

The patient died during the procedure while in the CT machine. The autopsy reportedly did not establish a definitive cause of death.

The family's experts testified that the patient was in respiratory distress and had a low level of oxygen saturation, which was not actually being monitored at the time, and most likely experienced a fatal cardiac arrhythmia.

The family's experts went on to say that a patient in this patient's condition should have had a nurse assigned to accompany him to the CT and to remain standing by to monitor his status throughout the procedure, which would have prevented his untimely demise.

The jury in the Circuit Court, Alachua County, Florida awarded the family $6,200,000 for the patient's wrongful death. **Fine v. Shands Teaching Hosp., 2010 WL 3483124 (Cir. Ct. Alachua Co., Florida, August 11, 2010).**

Surgery: Nurse's Error Leads To Verdict Against Surgeon.

The patient had a sigmoid colon resection and got a colostomy after an acute bout of diverticulitis.

Four months later the surgeon decided to do a second procedure to reverse the colon resection and take down the colostomy.

During the second procedure the surgeon was assisted by a nurse who was an employee of the hospital. The nurse was assigned responsibility for operation of the surgical stapler, that is, she was supposed to staple together the two segments of the sigmoid colon that were being reattached.

Instead of inserting the stapler into the colon the nurse reportedly inserted it into the patient's vagina and incorrectly carried out the stapling procedure. The patient defecated through her vagina for a number of days until the error was corrected.

The jury in the Circuit Court, Loudon County, Virginia awarded the patient $400,000 from the surgeon. **Dooley v. Shah, 2010 WL 3621827 (Cir. Ct. Loudon Co., Virginia, February 3, 2010).**

Emergency Room: Hospital Admits Liability For Cardiac Patient's Death From Heart Attack.

The forty-nine year-old patient reportedly died from a heart attack while lying on a gurney near the nurses station in the emergency department waiting to receive treatment.

He came to the emergency department with a complaint of burning pain in his throat. He was nauseous and vomiting and had an elevated respiratory rate and pulse.

There was a history of a prior coronary artery stent placement.

The nurse triaged the patient as not urgent and placed a call to the physician. An EKG was done, but the abnormal readout was not passed along to the physician.

The emergency room physician ordered cardiac monitoring but the nurses did not start a monitor. He was sent for x-rays and returned.

The hospital agreed to a pre-trial settlement with the family.

The amount of the settlement paid to the family is being kept confidential.

However, the hospital did agree to apologize publicly to the family for what happened and in addition to spend $1,250,000 over the next five years for expanded training of the emergency room staff.

SUPERIOR COURT
KENT COUNTY, RHODE ISLAND
February 1, 2010

The hospital's lawyers were prepared to argue that the EKG's computerized readout of "abnormal" was not definitive enough to change the overall assessment that the patient was not in need of immediate attention and care.

The family's lawyers were prepared to argue, on the other hand, that the patient's presenting signs and symptoms were a clear indication of an impending heart attack.

They were ready to point out that a cardiac monitor was never started for the patient as the nurse was ordered by the physician over the phone and that the patient was never actually seen by a physician before he died.

The lawsuit filed in the Superior Court, Kent County, Rhode Island settled before trial. **Woods v. Kent Hosp., 2010 WL 3440438 (Sup. Ct. Kent Co., Rhode Island, February 1, 2010).**