LEGAL EAGLE EYE NEWSLETTER

October 2011 *For the Nursing Profession* Volume 19 Number 10

Skin Lesions: Court Finds Nursing Care Was Appropriate In All Respects, Suit Dismissed.

After a careful review of the full gamut of legal rights guaranteed to nursing facility residents by Federal and state law, the Supreme Court, Kings County, New York ruled that the resident's nursing care was entirely appropriate and was fully documented.

Resident's Medical History

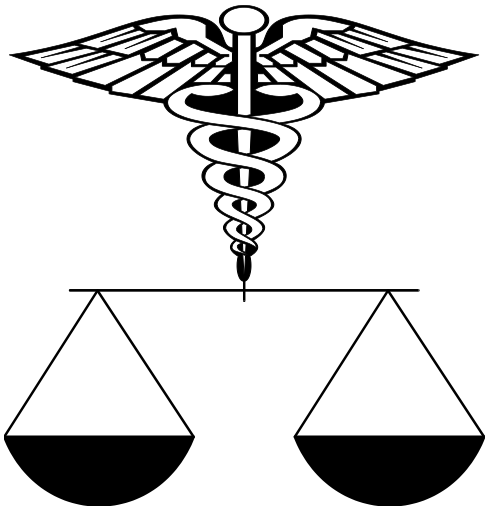
The ninety-one year-old man was admitted for rehab after lower-extremity vascular bypass surgery necessitated by gangrene in his left foot. He weighed only 71 lbs. at the time.

He had multiple gangrenous Stage IV ulcers on his left foot whose size and position were carefully documented on admission, and a Stage II sacral ulcer.

The admitting orders called for the nurses to clean the foot ulcers and apply wet-to-dry dressings and to wash the sacral ulcer with saline and apply Silvadene and a dry dressing q shift. Tylenol q 4 hours prn for pain was ordered along with antibiotics and medication for chronic heart failure.

Nursing Care

The nursing progress notes revealed that on average four times per day during his stay the ulcers on the left foot were cleaned and the wet-to-dry dressings were changed and the sacral ulcer was washed with saline, Silvadene was applied and the dressing was changed, as per the physician's orders.



Nursing facilities must ensure that a resident who already has pressure sores on admission receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Care and services must be provided to maintain the highest practicable level of physical and mental wellbeing.

SUPREME COURT
KINGS COUNTY, NEW YORK
September 14, 2011

When a suspicious odor was detected from the left foot the patient's attending physician was contacted and came in the next day.

The attending physician wanted a vascular surgery consult as well as a consult with a physiatrist, both of which the nurses arranged.

Despite the nurses' best efforts the patient's condition began to deteriorate. The nurses followed the physician's new orders for more potent pain medication to precede each q shift dressing change by thirty minutes.

Still the patient's status went downhill and he became lethargic and disoriented. When rapid respirations pointed to possible respiratory distress he was sent back to the hospital.

At the hospital his skin lesions and the necrosis of his left foot were assessed and documented as basically as far advanced as they had been on admission to the nursing facility almost a month earlier. Blood lab work indicated widespread systemic infection.

The family declined everything beyond O_2 and palliative care and the patient passed away in the hospital from cardiopulmonary arrest related to chronic obstructive pulmonary disease. **Butler v. Shorefront Jewish Geriatric Ctr., __ N.Y.S.2d __, 2011 WL 4346573 (N.Y. Sup., September 14, 2011).**

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October 2011

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Family And Medical Leave Act: Court Sees No Interference With Nurse's Right To Reinstatement.

A forty-two year-old RN was hired by the hospital as a staff nurse. Her job performance and evaluations were entirely satisfactory for almost two years before she was diagnosed with Meniere's disease, a disorder of the inner ear which involves hearing loss, tinnitus and vertigo.

Even as her nurse manager began to question her ability to do her job the nurse continued to work six months past her diagnosis until her own doctor recommended a medical leave to undergo a series of surgeries for her condition.

The nurse's supervisor approved a medical leave with a definite date specified when her available leave expired and she was required to return to work.

Nurse Unable to Return to Work When Medical Leave Expired

The US District Court for the Eastern District of Pennsylvania pointed out that the US Family and Medical Leave Act (FMLA) and a corresponding state law absolutely entitle eligible employees to take necessary unpaid leave from their jobs for legitimate medical purposes.

The flip side is that when the leave entitlement specified by law has expired, the employer is not required to reinstate the employee to the employee's former position or an equivalent position if the original position is no longer available.

In this case the nurse was not able to return to work on the date that had been specified when she went on leave, and the new return date was only one week beyond the maximum of her legal entitlement.

Her physician wrote a letter on her behalf requesting the additional week as reasonable accommodation to her disability, but a temporary medical condition is not considered a disability for purposes of disability discrimination law.

The Court left open the option for the nurse to keep her lawsuit alive by alleging employer retaliation. Her nurse manager repeatedly did not return phone calls when the nurse's husband phoned in weekly progress reports, possible evidence of personal animosity toward her for using FMLA leave. **Hofferica v. St. Mary Med. Ctr., 2011 WL 3474555 (E.D.Pa., September 20, 2011).**

An employee can sue for interference with Family and Medical Leave Act (FMLA) rights if the employee can show he or she was entitled to benefit from the Act and was denied.

One of the benefits of the Act is that when an eligible employee returns from leave, the employee is entitled to be reinstated to his or her former position or an equivalent position.

However, once an employee exceeds his or her allowable leave without returning, the employer is not obligated to keep open the employee's position or reinstate the employee upon his or her eventual return.

An employer may not terminate an employee because he or she has taken the leave permitted by law, but if the employee is not able to return to work after the 12-week period provided by law, the employer may terminate the employee.

In this case the employee has not even alleged in her lawsuit that she had any legally-protected leave time remaining when she was terminated for being unable to work.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
September 20, 2011

No Admission Assessment: Court Asks For Clarification From Patient's Experts.

The patient was admitted to the post-partum unit at 5:30 p.m. from post-anesthesia care where she had been showing signs of blood loss including a low BP.

One of her uterine arteries had been cut accidentally earlier that day by the surgeon during her planned cesarean.

The surgeon failed to notice the problem before he closed and sent the patient to the post-anesthesia unit.

The nurse who received the patient on the post-partum unit documented no admission nursing assessment or vital signs for the patient who was apparently having serious problems at the time.

The first chart documentation on the post-partum unit for the patient was a 5:45 p.m. note by the hospital's E.R. physician after he was summoned to the patient's bedside by the post-partum nurse.

COURT OF APPEALS OF TEXAS
August 25, 2011

The Court of Appeals of Texas was presented with the patient's nursing expert's report stating that the care by the post-partum nurse fell below the standard of care because she failed to document an admission nursing assessment including vital signs when she assumed the patient's care when the patient arrived on her unit.

However, given that the post-partum nurse saw good reason to summon the E.R. physician and took prompt action to summon the E.R. physician to the bedside, it was unclear how the nurse's failure to provide contemporaneous documentation had any affect on the patient's outcome.

The Court gave the patient's attorney 30 days to file a supplemental report from their nursing expert. **Methodist Willowbrook v. Cullen, 2011 WL 3806148 (Tex. App., August 25, 2011).**

Patient Suicide: Court Rules Hospital Not Liable.

The patient came to the E.R. complaining of depression, loss of appetite and insomnia. He was kept overnight and released the next morning after being examined by the chief of psychiatry who found no evidence of suicidality but instead diagnosed depressive disorder for which he prescribed two antidepressants and recommended an outpatient psychiatry consult.

The patient came back the next day and was admitted. This time the chief of psychiatry diagnosed major depressive disorder but again found no suicidal ideation, suicidal intent or suicide plan.

The next morning a hospital nurse assessed the patient. Due to lack of improvement she suggested he be transferred to a nearby hospital's inpatient psychiatric service. He opted instead to go home, but came back later that same day.

The same nurse saw him again and noted he did verbalize vague thoughts of suicide but had no intent or plan. He was allowed to stay in the hospital overnight pending insurance approval and transport to the other hospital's psych service for voluntary admission as recommended.

Still in the first hospital the next afternoon the patient was accompanied by a nurse for a blood draw and then to radiology where he was left unattended to wait for a chest film. Still another nurse saw him standing in the corridor with his gown untied in the back. She tied it up for him and left him alone with instructions to walk back to his room after his chest x-ray.

He was next seen standing out on the fifth-floor roof. As a nurse and two maintenance workers were going to intercept him the nurse yelled "hey" and he jumped from the roof and was killed.

A nurse who testified for the patient's family stated that the hospital's nurses violated the standard of care by failing to recognize the patient's potential for self-harm and for leaving him unattended despite the fact he was a psychiatric patient who was suffering from depression.

A nurse who cared for the patient testified for the hospital that one-on-one observation requires a physician's order and cannot be initiated by a nurse.

The hospital's chief of psychiatry testified he examined the patient but did not order close observation by the nurses because there was no overt indication of suicide risk and overly restrictive precautionary measures, such as constant supervision, can have a negative impact by increasing the patient's nervousness and anxiety.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
September 1, 2011

Hospital Ruled Not Liable For Wrongful Death

The Superior Court of New Jersey, Appellate Division, ruled in the hospital's favor and dismissed the family's lawsuit.

The evidence was insufficient that the patient presented signs of actual suicide risk, even though he was diagnosed with a major depressive disorder and was in the hospital awaiting transfer for voluntary admission to a psychiatric facility.

The nurses who interacted with the patient, like the physicians, found no definitive evidence of suicidal intent or a suicide plan. The patient was at all times alert, cogent and cooperative, showed good insight into his condition and was in the process of following advice voluntarily to obtain help for his psychiatric diagnosis.

According to the chief of psychiatry, it is not necessary or even advisable to institute close one-on-one observation unless the patient needs it, and nurses are not permitted to make the decision to do that without orders from the psychiatrist.

The hospital also had testimony from the head of maintenance that a patient would have to be very determined to reach the fifth floor roof, having to climb a ladder, open a hatch, climb over a water tank, climb up water pipes and open another hatch, an improbable sequence of steps. **Estate of Hetmanski v. Rahway Hosp., 2011 WL 3847147 (N.J. App., September 1, 2011).**

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Corrections Nursing: Nursing Negligence Leads To Verdict For Deceased Inmate's Family.

The suspect was arrested on narcotics charges and booked into the county jail. A physician performed an admitting exam which was unremarkable except for a slightly elevated pulse.

The inmate told the physician he used drugs so the physician prescribed medication to ease his withdrawal symptoms.

Six days later the inmate banged on the glass-enclosed station where the guards sat and gestured that he needed medical help by drawing an "M" in the air with his finger. Then he laid down and crossed his arms over his stomach while another inmate continued trying to get the guards' attention. After eight hours they went to his cell and took him to the infirmary.

Although by the next day he had been in jail seven days he told the nurses he was still kicking a drug habit. He was kept in the infirmary, but the nurses on duty did basically nothing for him but allow him to lie on a cot. At the end of the shift the nurse did not check on him or write anything in his chart or report anything to the nurse coming on duty.

Throughout the night the nurse on duty had minimal contact with him and the next morning she did not try to get a doctor to see him as he requested. Later that morning an inmate working in the infirmary told the nurse the inmate was unresponsive. CPR was not successful and the inmate was pronounced dead.

Autopsy Results
Perforated Ulcer, Peritonitis

The autopsy revealed an ulcer had perforated at least 24 hours before his death and signs of widespread infection.

The Superior Court of New Jersey, Appellate Division pointed to testimony from experts who testified for the family that heroin withdrawal was an unlikely explanation for his symptoms six days into his incarceration. Jail nurses would know that even without medication drug withdrawal symptoms peak within three days. The experts also testified the patient's ordeal would have produced excruciating pain for him to have to endure. **Williams v. Hudson County, 2011 WL 4008016 (N.J. App., September 12, 2011).**

The inmate patient's condition could have been easily detected and his death prevented had a proper examination of his abdomen been conducted and his fluctuating vital signs recorded, or if he had been sent to the hospital for a CT scan after he fell down and began to display an alteration in mental status.

The jail nurses failed to properly assess the inmate's condition, failed to objectively rule out an inappropriate diagnosis (heroin withdrawal), failed to document his symptoms and vital signs, failed to communicate with each other regarding the inmate's condition and needs, failed to contact the doctor and failed to send the inmate to the hospital.

The jail nurses were totally insensitive to the inmate's condition and essentially rendered no medical care whatsoever for him.

The inmate must have experienced excruciating pain as his condition worsened.

The jury awarded his family $600,000 for negligence, $225,000 for violation of his civil rights and $319,152 for attorney fees and costs.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
September 12, 2011

Sonogram Gel On The Floor: Patient Slipped And Fell.

A court decision has been reversed which we reported in June 2010: *Sonogram Gel On The Floor: Patient Slipped And Fell,* Legal Eagle Eye Newsletter for the Nursing Profession, (18)6, Jun. '10, p. 4.

In the process of doing a bladder scan a nurse somehow allowed some of the lubricating gel to get on the floor of the patient's hospital room.

The patient was injured when he got up to use the restroom and slipped and fell due to the presence of the gel on the floor.

The Court of Appeals of Texas ruled in May 2010 that the patient's lawsuit against the hospital could go forward without expert testimony.

That court said it would be common knowledge to any lay person sitting on a jury that a nurse should not let the lubricating gel get on the floor while doing a scan procedure, the risk being a safety hazard that could cause the patient to fall.

The patient's case should have been dismissed at the level of the trial court for failure to file an expert's report, as is required in Texas and in may other states.

SUPREME COURT OF TEXAS
August 26, 2011

The Supreme Court of Texas reversed the decision of the Court of Appeals without ruling one way or the other whether the nurse was negligent.

The Supreme Court believed the nurse wore gloves during the procedure, took them off, dropped one or both on the floor, then picked them up leaving a certain amount of the lubricating gel on the floor.

The technical legal issue in this case is the standard of care for a nurse, and for a hospital in setting standards for its nurses, for the removal and disposal of gloves worn during a medical procedure, a question that requires expert testimony. **St. David's Healthcare v. Exparza, __ S.W. 3d __, 2011 WL 3797685 (Tex., August 26, 2011).**

Discrimination: US Appeals Court Upholds Religious Institutions' Exemption.

A court decision has been reversed which we reported in June 2010: *Religious Discrimination: Court Defines the Limits Of Exemption For Religious Institutions,* Legal Eagle Eye Newsletter for the Nursing Profession (18)6, Jun. '10, p. 8.

A geriatric nursing assistant was a member of the Church of the Brethren. She worked in a nursing home run by an order of Catholic nuns and operated in all respects as a Catholic religious facility.

The nursing assistant's supervisor told her the long dresses and head coverings she wore on the job due to her own religious beliefs were inappropriate in a Catholic institution and were making some residents and their families feel uncomfortable. The nursing assistant refused to alter her attire and was fired.

The exemption for religious healthcare institutions from Title VII of the US Civil Rights Act applies across the board to all aspects of religious discrimination in employment, not just hiring decisions.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
September 14, 2011

The lower Federal court ruled in 2010 that the nursing assistant could sue for religious discrimination in the form of on-the-job harassment directed at her for her manner of dress mandated by her own faith.

The US Court of Appeals for the Fourth Circuit reversed the lower court on the grounds that the exemption from religious-discrimination lawsuits the US Congress gave to healthcare institutions associated with a particular religious faith applies to all aspects of employment, not just initial hiring decisions. **Kennedy v. St. Joseph's Ministries, __ F. 3d __, 2011 WL 4068458 (4th Cir., September 14, 2011).**

Misconduct: Nurse Terminated, Failed To Document Narcotics.

A registered nurse was terminated after a hospital medication audit found four instances in a two-month period where the nurse withdrew narcotics from the dispensing machine but did not document in the patients' charts that the drugs were actually administered to the patients.

There were also twenty-four instances in the same time period where he apparently did give the narcotic medications to the patients but failed to document the follow-up assessment that was required by hospital policy within sixty minutes.

When questioned by his supervisor about these incidents the nurse said he was not able to recall exactly what happened but assumed he simply forgot to finish his charting.

The nurse claimed he did not divert narcotics for personal use as he believed his termination implied.

However, he was not fired for narcotics diversion. He simply failed on numerous occasions to properly document administration of narcotics to his patients.

COURT OF APPEALS OF MINNESOTA
September 12, 2011

The Court of Appeals of Minnesota ruled the hospital had grounds to terminate the nurse for misconduct. It was not necessary for the hospital to prove the nurse diverted narcotics for his own use.

Failing to document administration of narcotics properly is a patient-safety issue, the Court said, the risk being that a patient could potentially suffer a negative outcome if another dose was administered because an earlier dose was not documented.

Being aware of the potential consequences and failing to do the required documentation is serious misconduct for a nurse. **Nimoh v. Allina Health, 2011 WL 4008313 (Minn. App., September 12, 2011).**

Discrimination: Nurse Did Not Give Adequate Report, No Racial Job Bias Found.

A nurse wanted to leave work an hour early. She asked another nurse if she could give report early. The other nurse told her she was too busy to take responsibility for the first nurse's patients or even to take report at that time.

A few moments later the first nurse told the other she had not had a lunch break, felt a migraine headache coming on and had to pick up her children from school. Even though she knew the other nurse had patients of her own on the opposite end of the floor she gave a brief report about her own patients and said she was leaving her cell phone number at the unit secretary's desk if she had any questions.

After the first nurse walked off the unit the other nurse went to the charge nurse with the fact the first nurse had left and she really could not manage that nurse's patients and her own at that time. The charge nurse paged the first nurse who reportedly heard her name being paged but walked out of the hospital.

There were legitimate, non-discriminatory grounds to terminate the nurse.

The nurse left her patient assignments without authorization, without properly reporting and under circumstances that amounted to patient abandonment.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
September 8, 2011

The US District Court for the Eastern District of Pennsylvania ruled the nurse, a minority, had no grounds to sue for race discrimination as she was fired for creating a situation which posed serious jeopardy to her patients' safety. **Morrison v. Thos. Jefferson Univ. Hosp., 2011 WL 4018252 (E.D.Pa., September 8, 2011).**

Informed Consent: Court Looks At Nursing Responsibilities.

The patient came to the medical center with kidney stones. Because the stones did not pass, surgery was necessary.

The center's policy was to require separate informed-consent forms for surgery and for anesthesia.

The nurse's role was limited to verifying that consent had been given, that is, before the nurse signed the informed-consent form as a witness to the patient's signature the nurse was expected to check to be sure that:

Information about the surgery was provided to the patient prior to surgery;

An explanation was provided to the patient by the anesthesia provider;

The patient or the patient's healthcare surrogate decision-maker gave consent to treatment after discussion;

The patient or surrogate was given the opportunity to ask questions about the proposed treatment and that all of these questions were answered fully;

All the blanks on the form were filled in with the necessary information; and

The patient or surrogate signed the form.

The medical center's policy went on to say that the physician and the anesthesia provider were to obtain consent from the patient after they had advised the patient as to the risks, drawbacks, complications and expected benefits of the surgery and the method of anesthesia.

Nurse Merely Had the Patient Sign The Anesthesia Consent Form

The nurse got the patient to sign an anesthesia-consent form which was blank as to the type of anesthesia that was to be used. Nor had the anesthesia provider, a certified registered nurse anesthetist (CRNA) even met with the patient or given the patient any information before the patient signed the form at the nurse's behest.

The CRNA reportedly had trouble administering the spinal block and made quite a number of puncture wounds in the patient's back. Afterward a physician diagnosed a serious inflammatory condition known as arachnoiditis that was caused by the multiple spinal punctures.

The Court of Appeals of Arkansas saw grounds for a lawsuit by the patient against the medical center.

The medical center claimed the nurse met the requirements of the medical center's informed-consent policy by getting the patient to sign a blank consent-to-anesthesia form and then signing it as the witness to the patient's signature.

However, it is not clear how that was anything more than an empty gesture, given the fact the patient had received no information about anesthesia before he signed the form.

COURT OF APPEALS OF ARKANSAS
September 7, 2011

Informed Consent
Nursing Responsibilities

The Court agreed with the medical center it is not a nursing responsibility to obtain informed consent for anesthesia. That was the legal responsibility of the CRNA who was an independent contractor and not an employee of the medical center.

However, the medical center's policy for its employee nurses in regard to informed consent went beyond the mere formality of having the patient put a signature on the necessary paperwork.

It is a nursing responsibility, not to provide the information necessary for informed consent but to verify that the patient has been given the necessary information by the provider to make a truly informed decision to consent to surgery or surgical anesthesia. That essential nursing responsibility was completely absent in this case, according to the Court.

An invalid informed-consent document is no informed consent at all and no legal defense to liability if the patient claims he or she would not have had the procedure if he or she had actually known what was really involved. **Villines v. North Arkansas Reg. Med. Ctr., __ S.W. 3d __ , 2011 WL 3916143 (Ark. App., September 7, 2011).**

O.R.: Perioperative Nurse Advocated For The Patient.

After a CT scan revealed a mass in the patient's colon the physicians decided he needed to have surgery.

He was taken to the surgical suite and placed under anesthesia at 9:30 a.m. Then several hours went by while the general surgeon who was in the operating room attempted to contact a colorectal surgery specialist to come and take over the case.

At 12:30 p.m. a colorectal surgeon came in, examined the large intestine with a sigmoidoscope and continued as the surgeon on the case.

At 4:30 p.m. one of the O.R. nurses voiced her concern to the colorectal surgeon over the fact the patient had been in the lithotomy position for a number of hours and should be repositioned.

The surgeon acknowledged the nurse's concerns but did not change the patient's positioning.

COURT OF APPEALS OF KENTUCKY
September 23, 2011

At 10:40 p.m. the colorectal surgeon finished the case. It was discovered there was no pulse in either of the patient's legs. Circulation soon resumed in the right leg, but not the left. The left leg had to be amputated below the knee a week later.

The Court of Appeals of Kentucky approved a jury verdict which found no negligence by the hospital. The nurse, a hospital employee, had done her legal duty by advocating for her patient.

The colorectal surgeon, an independent contractor, was also found not liable due to technical problems with the patient's experts' formulation of how the medical literature defined the standard of care for padding and positioning a surgical patient in 2003 when the incident occurred. **Carroll v. Univ. Med. Ctr., __ S.W. 3d __, 2011 WL 4407449 (Ky. App., September 23, 2011).**

O.R.: Inadequate Padding, Nurses Held Responsible.

The Court of Appeals of Texas accepted the testimony of an out-of-state physician retained as an expert for the patient that the perioperative nurses share responsibility with the surgeon and the anesthesia provider to see that the patient's body and limbs are positioned and padded appropriately for surgery.

It was not altogether clear how the patient in this case sustained an injury to her brachial plexus, which the expert described as a plexopathy, while she was undergoing gynecological surgery.

However, in operating-room lawsuits the exact mechanism of injury does not always have to be made clear.

It was very clear that the patient did not have any problems with her arms or shoulders beforehand and that she was diagnosed by her own physician with an arm and shoulder injury afterward.

One of the post-anesthesia unit nursing chart entries, four hours after the end of the procedure, noted the patient was unable to move her arm after she awoke from anesthesia.

None of the other nursing charting mentioned this problem, indicating either that the other entries were falsified or the nurses were not monitoring the patient very carefully at all.

COURT OF APPEALS OF TEXAS
August 31, 2011

The patient's hired expert was particularly critical of the nursing care in the post-anesthesia unit.

Only one entry was made about the problem with the patient's arm. Then an hour later a call was placed to the physician's office but no one actually spoke with the physician until he happened to drop by sometime later that evening. **Padilla v. Loweree, __ S.W. 3d __, 2011 WL 3841306 (Tex. App., August 31, 2011).**

Med/Surg Nursing: Court Sees No Problem With Insulin, Lack Of Restraints, Lawsuit Dismissed.

The rationale behind the facility's policies for physical restraints was to provide the most therapeutic and least restrictive environment for the facility's patients.

The use of physical restraints required a time-limited order from the physician and documented clinical justification, to protect the patient from injury and/or disruption of the therapeutic environment.

The facility's policy stated that the registered nurse caring for the patient was still authorized to provide early release after restraints were ordered by the physician if the patient demonstrated a significant reduction of the behavior that led to restraints being ordered in the first place.

The jury accepted testimony from one of the patient's nurses and the hospital's nursing expert that the nurses made a correct judgment call not to restrain the patient after her transfer from the ICU to a med/surg floor, a transfer it was believed was indicated to counteract the confusion and agitation the patient had been experiencing while restrained in the ICU.

COURT OF APPEAL OF LOUISIANA
September 21, 2011

The sixty-seven year-old patient's physician had her admitted to the hospital for abnormal weight loss, nausea, vomiting, diarrhea and weakness. She had previously been worked up for renal failure and chronic respiratory problems.

Insulin

An erroneous high blood glucose level was reported by the lab. The physician ordered the nurses to do q 6 hour one touch glucose readings and specified a sliding-scale for insulin injections.

The nurses got glucose readings and documented them, all below 180, which called for no insulin to be given. In the morning a correct insulin level came back and the physician discontinued the orders.

Later that day in the endoscopy lab the patient became hypotensive and her blood glucose was only 36, but she recovered and was returned to her room.

The Court of Appeal of Louisiana ruled that the family's expert witness was able at best only to speculate that the nurses could have given insulin and caused the hypoglycemic episode.

Restraints

The patient became confused and combative and was sent to the ICU. Restraints were applied to keep her from removing her O_2 and IV. The husband asked the nurses if the restraints could be removed. He and the ICU nurses and the physician had a conference where the physician agreed to transfer her back to the med/surg floor, on the understanding the husband would sit with her.

Soon after she arrived on the med/surg floor she was found in her chair with her mask off and her IV lines out. A code was called, she was intubated and sent back to the ICU and eventually discharged home.

The jury accepted a nursing expert's testimony it was acceptable nursing judgment not to restrain the patient on the med/surg floor, given the patient's condition, her husband's agreement to sit with her and the overall goal of treatment to tone down her confusion and agitation from having been restrained in the ICU. **Hays v. Christus-Schumpert, __ So. 3d __, 2011 WL 4374564 (La. App. September 21, 2011).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Emergency Trauma Care: Court Faults Nursing Assessment, Failure To Advocate.

During a rollover accident the patient was ejected from the bed of the pickup truck in which he was riding.

He was taken to the hospital by ambulance shortly after midnight. He was examined by the E.R. nurse and by the E.R. medical staff.

An hour and fifteen minutes after being discharged at 6:45 a.m. the patient collapsed and had to be taken back to the same E.R. He died in the hospital at 9:26 a.m. that same morning despite resuscitation efforts, allegedly from a broken neck which was not diagnosed earlier.

Lawsuit Alleges Negligent Nursing Care

The family's lawsuit filed in the US District Court for the District of Arizona alleged negligence by the medical staff at the hospital, a US Indian Health Service facility, and specifically on the part of the E.R. nurse.

As Federal employees the physicians and nurses in a Federal facility cannot be sued individually. Nevertheless the Court took the time to rule that the allegations pointed at the physicians were too vague to go forward, while the allegations pointed at the nurse stated valid grounds for a professional negligence lawsuit.

The E.R. nurse's assessment revealed complaints of pain of 8 and 9 on a scale of 1-10. The patient needed assistance walking to the bathroom, getting up from the commode and putting on a hospital gown.

The nurse reportedly never assessed for signs of spinal trauma before removing the restraints that had been applied to keep the patient's head and cervical spine immobile.

The nurse did not advocate on the patient's behalf for follow-up scans in the radiology department, for transfer to a higher-level trauma center, for a full medical workup before discharge or against his discharge from the hospital while he was still in considerable pain with a recent history and signs of serious injury.

Failing to advocate for the patient is considered a violation of the legal standard of care applicable to nurses.

The nurse's negligence led directly to the patient's discharge from the hospital with an undiagnosed cervical fracture and, ultimately, to his death, the Court ruled, valid grounds for a civil lawsuit seeking damages from the US government. **Mathis v. US, 2011 WL 43522981 (D. Ariz., September 16, 2011).**

Arbitration: Daughter Had No Authority To Sign For Incapacitated Father, Case Proceeds In Court.

After a seven-month stay in a long-term care facility ending with the patient's death the patient's daughter filed suit as personal representative of the patient's probate estate alleging negligence and violation of his statutory rights as a long-term care resident.

The legal issue at this time is the facility's argument that the case belongs in arbitration and is not appropriate for jury trial in civil court.

The Court of Appeals of Kentucky rejected the facility's call for arbitration on the basis that the arbitration agreement is not valid that was signed by the patient's daughter the day after the patient's admission.

The Court said that because the patient was mentally incapacitated at the time of his admission to long-term care it was legally impossible for him to have given his daughter permission to sign on his behalf.

The patient could not have done anything to confer authority on his daughter to sign legal documents on his behalf.

He was mentally incapacitated at the time of admission to the nursing facility.

Being the adult daughter of an adult patient, in and of itself, does not create a relationship where the former is the agent for the latter in signing documents or handling legal affairs.

COURT OF APPEALS OF KENTUCKY
September 23, 2011

The daughter simply placed her signature on the arbitration form as she was asked by the facility's personnel.

The daughter never told anyone or held herself out as having authority to sign on her father's behalf. She never claimed to be the court-appointed guardian or to have been named as his healthcare decision-making surrogate in a durable power of attorney.

In fact there was no court appointed guardian or durable power of attorney.

According to the Court, being an adult family member of an adult patient, in and of itself, does not provide a valid basis for signing legal documents on behalf of the family member. **Kindred v. Smith, __ S.W. 3d __, 2011 WL 4409599 (Ky. App., September 23, 2011).**