LEGAL EAGLE EYE NEWSLETTER

October 2012 *For the Nursing Profession* Volume 20 Number 10

EMTALA: Nurse's Screening Met Hospital's Legal Responsibilities, Lawsuit Dismissed.

The patient came to the emergency department at 5:47 p.m. and was seen by the triage nurse at 5:55 p.m.

The triage nurse asked him about the onset and severity of his chest pain, whether he had attempted self-treatment and whether he was a victim of domestic violence.

She obtained a pulse oximeter value and documented that the patient had taken an aspirin before coming to the hospital.

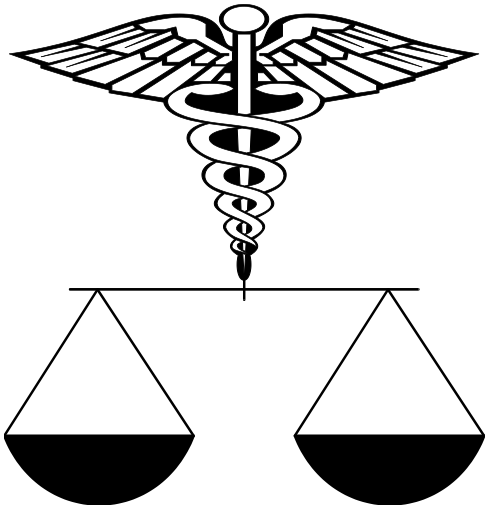
The nurse also began documenting the patient's cardiac risk factors including his BP, tobacco use and personal and family history of heart disease.

Then the nurse ordered an EKG which was done by an E.R. tech at 6:27 p.m. The EKG was not abnormal. The nurse had blood drawn at 6:40 p.m. for a cardiac enzyme work-up and sent him for a chest x-ray at 6:43 p.m.

At 7:50 p.m. the blood work came back positive for a possible cardiac event. The nurse promptly reported the lab results to the E.R. physician who immediately came in and evaluated the patient and talked with a cardiologist.

No Violation of EMTALA

The US District Court for the Eastern District of Pennsylvania dismissed the patient's suit alleging violation of the US Emergency Medical Treatment and Active Labor Act (EMTALA).



The US Emergency Medical Treatment and Active Labor Act (EMTALA) requires a hospital that has an E.R. to give every E.R. patient the same emergency medical screening examination that it gives its other E.R. patients with the same signs and symptoms.

The nurse fully complied with the hospital's protocols for E.R. patients with chest pain.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
September 19, 2012

The hospital's standing nursing protocol for E.R. patients with chest pain was to assess the patient with a physical examination, question the patient about his or her symptoms, screen the patient for domestic violence and create a record of risk factors.

Following the assessment, if a cardiac event was suspected, the nurse was expected to obtain a pulse oximeter reading, assign the patient the appropriate triage classification and alert other E.R. personnel to the patient's need for immediate treatment.

The nurse was then permitted to give aspirin, obtain an EKG, start O_2, order blood drawn for a cardiac work-up and obtain a chest x-ray.

The patient's emergency medical screening by the E.R. triage nurse fully complied with the hospital's standing nursing protocols, was completely appropriate and was basically identical to the emergency medical screening afforded by the hospital to other emergency patients with chest pains.

For the hospital's court case the hospital got an affidavit from its vice president, a physician, that this patient's care was basically identical to 136 other E.R. patients with chest pains at the hospital in the preceding month. **Byrne v. Chester Co. Hosp., 2012 WL 4108886 (E.D. Pa., September 19, 2012).**

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E.R. Nursing/Emergency Medical Treatment And Active Labor Act
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Psychiatric Nursing/Gravely Disabled Patient/Psych Placement
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ICU Nursing/Adult Patient - Pediatric Intensive Care Nursing
Correctional Nursing - Skin Breakdown/Nurse As Expert Witness

Whistleblower: Court Says Nurse Was Not Fired For Speaking With Investigators.

A patient died in the nursing home while the nurse was on duty as the charge nurse.

The incident was investigated by the state Department of Health. The nurse was among several employees who were interviewed by state investigators.

The investigators checked to see that caregivers at the nursing home had current CPR certifications. The nurse herself had a CPR card with an expiration date that might have been forged. The nurse was suspended, but then was reinstated with back pay several days later. The issue was dropped and the disciplinary write-up was pulled from her personnel file.

However, she was nonetheless written up for failing to notify the resident's physician until after the local police had looked into the circumstances of the death and had found nothing suspicious. The physician should have been notified immediately.

A number of other episodes involving substandard patient care eventually led to the nurse's termination. She sued for retaliation, claiming protected legal status as a whistleblower over the fact she had spoken with Department of Health investigators about the patient's death.

The US Court of Appeals for the Sixth Circuit (Ohio) dismissed her case.

No Evidence of Retaliation

State whistleblower laws say that no employer may retaliate against an employee who reports suspected abuse or neglect or who provides information in the course of a government agency investigation of suspected abuse or neglect.

The central question in this case was the employer's motivation for firing the nurse. Was it the fact she had spoken with state investigators, or was it the fact there were multiple disciplinary write-ups over patient care deficiencies?

The Court concluded that the facility had carefully investigated and thoroughly documented the underlying facts behind the disciplinary write-ups and had legitimate grounds to fire the nurse, apart from the fact she had spoken with state investigators. **Tingle v. Arbors, __ F. 3d __, 2012 WL 3711439 (6th Cir., August 29, 2012).**

Can the nurse show that her disciplinary write-ups were only a pretext behind an illegal motivation on her employer's part to fire her for speaking with state investigators looking into a patient death in the facility?

If the write-ups were just a pretext, then the nurse has rights as a whistleblower.

If the employer has an honest belief that there are valid independent grounds for disciplining or firing an employee, apart from the fact the employee has reported abuse or neglect or participated in a governmental investigation of suspected abuse or neglect, then the employer is on solid legal ground.

The employer's claim of an honest belief is necessarily tied to the nature and thoroughness of its investigation and documentation of the disciplinary process.

Did the employer make a reasonably informed and considered decision? Can the employer point to the particular facts upon which its decision was based?

The nurse cannot prove her former employer did not honestly believe there were grounds to terminate her.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
August 29, 2012

Cardiac Care: Court Does Not Find Nurses Liable In Patient's Death.

The eighty-one year-old patient was brought to the hospital's emergency department with chest pain, left-arm numbness, back discomfort and nausea. A cardiologist admitted her as an inpatient.

The next day the cardiologist did a diagnostic cardiac catheterization, found significant blockage and inserted a stent.

The cardiologist ordered Heparin and Plavix. The nurses did not give the Plavix for almost twenty-four hours.

At 6:04 a.m. the day after the catheterization an EKG revealed that the patient had had a heart attack. The physician was not notified and did not find out until he came in on rounds at around 9:00 a.m.

The patient's condition continued to deteriorate. She coded the next day, was put on no-code status and passed away.

Assuming the nurses were negligent for delaying the Plavix almost twenty-four hours after the first catheterization and for not reporting the abnormal EKG promptly to the physician, there is no proof that caused or even contributed to the patient's death.

SUPREME COURT OF ARKANSAS
September 13, 2012

The Supreme Court of Arkansas accepted expert testimony faulting the nurses for negligence in the patient's care.

However, there was also ample evidence in the case that the patient was suffering from persistent hypotension, renal failure, liver failure, acidosis and cardiogenic shock.

There was no solid proof that the nurses giving the Plavix or notifying the physician right away about the EKG would have made any difference in the outcome, the Court ruled. **Neal v. Sparks Reg. Med. Ctr., 2012 Ark. 832, __ S.W. 3d __, 2012 WL 4017368 (Ark., September 13, 2012).**

Gravely Disabled Nursing Home Patient: Court OKs Legal Proceedings For Psych Placement.

The nursing home patient already had a court-appointed legal guardian to manage her affairs due to the fact that she was not mentally competent to sign legal contracts and was not able to consent or refuse consent to medical treatments.

However, the existing court-appointed guardianship did not include legal authority to admit the patient against her expressed wishes to a psychiatric facility for mental-health treatment.

Patient Began Delusional Behavior
Refused to Eat / Refused Medications
Tried to Elope / Attempted Suicide

Staff at the nursing home became concerned about the patient's delusional behavior. The nursing home did not have a psychiatrist on its medical staff and its care-giving personnel were not trained to handle psychiatric patients. The patient's behavior became a major disruptive factor affecting other patients. The patient's own personal care and mental-health needs were not being and could not be fulfilled.

At the nursing home's urging the public guardian associated with the probate arm of the local county superior court filed a legal proceeding to be appointed the patient's conservator with specific authority to find an appropriate psychiatric placement and admit the patient, even against her expressed wishes.

Because the nursing facility was unable to manage the patient's mental-health needs and her needs were not being met at the nursing home, she needed a higher level of care.

The public guardian filed a court proceeding to be appointed her conservator, which would give him authority to place her in a psychiatric facility that could meet her needs.

The legal standard is whether the patient is gravely disabled.

Gravely disabled means that due to a mental disorder the person is unable to provide for his or her basic personal needs for food, clothing or shelter.

The psychiatrist testified that due to psychotic delusions the patient persistently refused to eat, frequently tried to elope and had attempted suicide.

CALIFORNIA COURT OF APPEAL
September 12, 2012

Patient Was Gravely Disabled

The county prosecuting attorney and the patient's own court-appointed public defender agreed to accept the credentials of the senior psychiatrist with the county mental health services as an expert witness.

His review of the history revealed the patient had a long-standing pattern of not being able to care for herself. She had been in psychiatric hospitals and had been diagnosed with bipolar disorder with psychotic features and was supposed to be taking psychotropic medications.

Currently the patient was having bizarre psychotic delusions that made her refuse to eat, refuse to take her psych medications and try to elope from the nursing facility several times. She had also attempted suicide in the facility.

The California Court of Appeal agreed with the psychiatric expert that the patient was gravely disabled as a result of a mental disorder and required a higher level of care than that available at the nursing home. The legal vehicle for seeing that her needs were met was for the public guardian as her conservator to remove her from the nursing home in favor of a secure psychiatric placement.

A nursing home placement was a less restrictive alternative to a locked psychiatric facility, but it was not appropriate to meet her safety needs in view of her history of repeated elopement attempts. It was also not appropriate to return her to her family's care as they had originally been forced to place her in the nursing home. **Conservatorship of Marjorie F., 2012 WL 3898891 (Cal. App., September 12, 2012).**

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Patient Created Racially Hostile Workplace: Aide's Case Nixed.

A hospital nurses aide sued the hospital where she worked alleging racial discrimination in the form of a racially hostile work environment and in the form of retaliation for her complaints.

The aide was assigned to care for a patient who was known to make intolerable racist comments to minorities and used the "N-word" toward her.

The US Court of Appeals for the Second Circuit (New York) dismissed the suit.

Hospital Did Not Create Racially Hostile Work Environment

A lawsuit for a hostile work environment must be supported by evidence that the harassment was sufficiently severe or pervasive as to alter the conditions of the victim's employment by creating an abusive working environment. A basis must exist for imputing the harassing or abusive conduct to the employer itself.

According to the Court, it is not enough to make out a case of a hostile work environment to say that the hospital was aware of and was unable to control the racist outbursts of a demented patient. There was no basis to say that the patient was operating on behalf of the hospital when he acted out as he did.

Hospital Did Not Retaliate For Complaint About Patient's Behavior

The aide also alleged in her lawsuit that she was the victim of retaliation for her complaints about the patient's objectionable racist behavior.

An employer is not permitted to retaliate against an employee who opposes an employer practice forbidden by the anti-discrimination laws or who assists or participates in an investigation or legal proceeding related to charges of discrimination brought by the employee or another.

Again the Court pointed out that the patient's racist behavior was not an action or employment practice by the hospital.

The aide was assigned this patient after a nurse objected to the aide reporting a patient of hers for drug usage on the unit and had her assignments switched so she would longer work with that patient. The aide herself never claimed that race was a factor in that action, the Court said. **Wright v. Monroe Community Hosp., 2012 WL 3711743 (2nd Cir., August 29, 2012).**

The nurses aide based her hostile work environment lawsuit on the fact that she was assigned to care for a patient who made intolerable racist comments to her specifically and was known to target minority caregivers in general with accusations and to lodge frequent complaints against them.

The patient repeatedly taunted the aide with racial epithets including the "N-word."

When the aide complained about the patient's behavior her supervisors refused to acknowledge her complaints and simply told her that the patient suffered from dementia and she would just have to learn to deal with it.

The aide did not allege in her lawsuit that her supervisor's decision to assign this patient to her was based on racism by her supervisors or hospital management.

While the patient's alleged behavior is certainly objectionable, the Court cannot conclude from the facts alleged in the aide's lawsuit that there is any reasonable basis for imputing the patient's objectionable conduct toward the aide to the hospital itself.

UNITED STATES COURT OF APPEALS
SECOND CIRCUIT
August 29, 2012

Discrimination: Minority Nurse's Jury Verdict Upheld.

Two female nurses, one an immigrant from Ghana, one a Caucasian, who worked together in the emergency department, got into a physical altercation on the hospital premises.

The minority nurse claimed the other nurse started with racial epithets and then physically attacked her. The Caucasian nurse testified just the opposite, that she was the victim of an unprovoked assault.

After the incident the minority nurse was suspended without pay and then was terminated. She sued for race discrimination and was awarded $385,000 as damages plus $249,525 as fees for her attorneys, all to be paid by the hospital.

The Superior Court of New Jersey, Appellate Division, upheld the jury's verdict.

There were no eyewitnesses to the altercation between the minority nurse and her co-worker, although those within earshot said they heard both parties yelling at each other.

The minority nurse was automatically deemed the aggressor. She was suspended without pay, while the other nurse continued to work. Only the minority nurse was terminated.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
September 10, 2012

The Court saw further evidence of uneven discipline and an overall discriminatory climate at the hospital in the fact the minority nurse was previously reprimanded several times for temporarily leaving her post in the emergency department while her Caucasian co-workers were never reprimanded for exactly the same conduct. **Ofori v. Univ. of Medicine, 2012 WL 3889134 (N.J. App., September 10, 2012).**

Medication Errors: Court Upholds Aide's Firing.

A home health aide worked in a group home for residents with traumatic brain injuries. Her job included administering medications to residents and documenting the medications in the medication administration record.

For medication errors the group home's policy was to counsel and warn an employee for the first four incidents and then to terminate the employee after a fifth.

The aide was terminated after her fifth medication error, having been counseled and warned after each of four previously.

The facility's policy is for employees to document medications as the medications are administered.

The aide had been told and she knew what the policy was, yet she waited until the end of her shift to document her medications in the medication administration record.

The aide was guilty of misconduct and her termination was justified.

COURT OF APPEALS OF MINNESOTA
September 17, 2012

The Court of Appeals of Minnesota upheld her employer's right to terminate her for just cause.

Employment misconduct includes intentional, negligent or indifferent conduct that seriously violates the standards of behavior the employer has the right reasonably to expect from the employee.

The Court ruled that failing to document medications as they are administered, but instead waiting until the end of the shift, is misconduct for a care-giving employee, if the employee knows the employer's policy is contemporaneous documentation. The Court was not willing to accept being too busy as an excuse. **Matoke v. Restart, Inc., 2012 WL 4052667 (Minn. App., September 17, 2012).**

Chemical Sensitivities: Court Turns Down Nurse's Disability Discrimination Lawsuit.

The question is whether the nurse is a qualified individual with a disability, that is, whether she can perform the essential functions of her job with reasonable accommodation.

The evidence shows that due to her occupational asthma and multiple chemical sensitivities the nurse was having reactions to a wide range of chemicals used by her employer and to substances common in hospital environments.

While having a reaction or when treating such a reaction with medications the nurse was unable to concentrate, respond to an emergency, make clinical judgments or deliver patient care safely and effectively.

Often her reactions forced her to leave her workplace and not return for extended periods of time.

Accordingly, her condition rendered her unable to perform the essential functions of a staff nurse.

No reasonable accommodation was possible because her employer could not guarantee she would never come into proximity with the chemicals commonly used in its facility.

UNITED STATES COURT OF APPEALS
ELEVENTH CIRCUIT
September 7, 2012

A hospital staff nurse sued her former employer for disability discrimination related to her multiple chemical sensitivities.

The US Court of Appeals for the Eleventh Circuit (Georgia) dismissed the suit.

For the record the Court noted that the nurse was allergic to a wide range of chemicals used and substances commonly found in her workplace and in other institutional hospital environments. These included floor wax, floor sealant, floor stripper, cleaning products, chemical solvents, ammonia, rubbing alcohol, sprays, molds, dust, perfumes, scents, latex, volatile compounds and asbestos.

Disability Discrimination
Qualified Individual With a Disability

To benefit from discrimination laws in the US an individual must be a qualified individual with a disability, one who, with or without reasonable accommodation, can perform the essential functions of the employment position the individual holds or desires to obtain.

Reasonable accommodation can include making existing facilities accessible and usable, job restructuring, acquiring or modifying equipment or modifying employment policies.

The employee has the responsibility to identify an accommodation and to prove that the accommodation is reasonable.

The employer is not required to create alternative opportunities for disabled individuals, reassign the employee to a position which is not vacant or to reallocate job duties or change the essential functions of the job.

The Court ruled the nurse was not qualified for her position because she could not function as a nurse while experiencing an allergic or asthmatic reaction.

Nor was there any reasonable accommodation her employer could make that would keep her out of proximity to any and all of the common substances her physician certified could and likely would provoke a reaction. Thus she could not sue for disability discrimination. **Dickerson v. Secty. of Veterans Affairs, 2012 WL 3892196 (11th Cir., September 7, 2012).**

Adult Intensive Care: Court Upholds Verdict Finding Nurses Only Partially Responsible.

The forty-one year-old patient was transferred to the intensive care unit after an otorhinolaryngologist surgically packed a posterior nosebleed which had brought the patient into the hospital's emergency department.

Unlike an anterior nosebleed which only involves bleeding inside the nose, a posterior nosebleed is a potentially life-threatening condition involving bleeding at the base of the skull behind the nose in the upper throat. He had lost half his blood volume and had been in respiratory arrest.

It was believed the patient's nosebleed was related to his hypertension and his use of aspirin products

He was admitted to the ICU because he was on a ventilator and possibly suffered from underlying illness or organ pathology that had caused the nosebleed to start. The nose packing could cause him to stop breathing. He needed a nurse to be near him at all times.

Jury Finds Hospital's Nurses 25% at Fault

The physicians all settled before trial. With the hospital as the only remaining defendant in the lawsuit the jury assessed the patient's damages at $1,800,000. However, the jury also ruled the patient was 75% responsible for his own injuries. After deducting the physicians' settlements from 25% of the jury's verdict the hospital's net exposure was $37,500. The California Court of Appeal affirmed the result.

Patient's Nursing Care in the ICU

At the time he was moved to the ICU he understood questions and responded by shaking his head or squeezing the hand. His physician explained what had been done for him and why he was in the ICU. Ativan was ordered to help with the disorientation that is common with ICU patients.

The first nursing note suggesting a problem was at 6:00 p.m. on the second day in the ICU. The patient was periodically anxious and mildly agitated. By 8:00 p.m. the patient was alert and cooperative.

At 4:00 a.m. the next morning the patient was getting more anxious and wanted the tube taken out. At 6:37 a.m. the nurse noted the patient had been very restless and anxious and wanted to eat. The endotracheal tube was removed.

The hospital's nursing expert is a clinical nurse specialist in critical care who practices as a nurse practitioner in another hospital's cardiology department.

She testified all the hospital personnel on duty the morning the patient coded acted within the standard of care and made heroic efforts to reinstate his respiratory effectiveness.

The patient's family's medical expert testified the nasal packing technique used with this patient in 2002 is not used anymore.

It can result in a "ball-valve" phenomenon where the person sucks the packing into the trachea when breathing in while there is no obstruction when breathing out.

When a ventilator patient starts picking at his electrodes, trying to remove his telemetry equipment and his IVs and wants the endotracheal tube taken out, it can be a sign that the patient is panicking due to an airway obstruction.

The panic the patient shows with an airway obstruction can be compounded by changes in the patient's mental status which the nurses should recognize as the result of lack of oxygen.

CALIFORNIA COURT OF APPEAL
September 18, 2012

At 2:34 p.m. the nurse noted the patient had to be repeatedly instructed not to remove his oxygen mask. Later that p.m. the nurses noted the patient was anxious, restless and non-compliant.

That evening the patient was trying to get to the bathroom to examine the packing in his nose. He was apparently unaware of all the previous teaching. The nurses told a family member they were considering restraints because the patient had tried to remove his Foley and the nasal packing.

The next day a nurse sat with him because he was picking at his electrodes and IVs and said he wanted to go home. After a phone report to the physician the nurse was told to repack one of the nostrils.

The next morning the patient complained his nose was plugged and a nurse reminded him not to pull at the packing.

The patient was sent from the ICU to a special care unit. He had been extubated and did not appear to be having breathing problems. His nurse noted he was oriented but confused and forgetful and was removing his heart telemetry electrodes.

The next day his 8:00 a.m. appointment to have the packing removed was reset to 4:00 p.m. because of the physician's schedule. A nurse listened to his lungs. His O_2 sat was 96%. He was not anxious but was impatient to leave. At 9:00 a.m. he was pulling at the packing in his nose but was not in respiratory distress.

At 10:00 a.m. a family member called an aide into the room. The patient was sitting on the side of the bed with his head in his hands.

He was having trouble breathing so respiratory therapy gave him a nebulizer treatment. Then a nurse was called from the ICU. She came in and called a code.

The patient was rushed to surgery to remove the packing. The surgeon concluded from what he found that the patient had compromised his own airway by trying to remove the packing himself with scissors mysteriously supplied to him.

The patient was left with profound hypoxic encephalopathy and was transferred from the hospital to a nursing facility in a persistent vegetative state. **Charalambopolous v. UHS, 2012 WL 4078783 (Cal. App., September 18, 2012).**

Pediatric Intensive Care: Court Looks At The Nursing Standard Of Care For Trache Patient.

The two-week-old infant was transferred to the hospital's pediatric intensive care unit (PICU) from another hospital for management and treatment of a rapid heartbeat.

The family's lawsuit alleged that the patient's PICU nurse asked the mother to feed the infant. The infant became fussy and the mother wanted to ask the nurse for help but the nurse was not available and did not respond right away. When the nurse finally came to the bedside she saw an air bubble under the baby's skin.

The nurse thought the trache tube was obstructed and she panicked. She tried and failed to replace the tube. She tried to suction the tube site but did not repeat the suction. She did not attempt to replace the trache tube with one of a smaller size. After more than thirty minutes trying to solve the problem on her own, the PICU nurse called a code. The code team were able to resuscitate the infant.

The Court of Appeals of Texas reviewed the opinions of the family's nursing expert and medical expert and ruled there were grounds for the family's lawsuit against the nurse and her employer the hospital to proceed to a jury trial.

Nursing Expert's Opinion
Standard of Care

If a displaced tracheostomy tube is suspected, the standard of care requires bilateral auscultation of breath sounds, observation of chest rise and fall and use of an exhaled CO_2 detector to assess for placement. An obstructed tube is suspected with decreased breath sounds bilaterally or decreased chest rise and fall.

The standard of care requires that saline be injected into the trache tube to thin secretions, then a properly sized suction catheter is to be passed into the tube and suction applied to clear secretions.

If the obstruction is still present, the procedure is to be repeated with ventilation attempted between attempts.

If there is no improvement in respiratory distress the trache tube is to be changed immediately. If the tube does not pass easily, the attempt is to be made immediately with a smaller sized tube to re-establish an airway.

The family's nursing expert is qualified to express an expert opinion on the standard of care applicable to the nurse caring for this patient in the hospital's pediatric intensive care unit.

She is a registered nurse and has a bachelor's degree and a master's degree in nursing and is pursuing a doctorate.

She has spent her entire fifteen-year career in pediatric intensive care environments working in or supervising nurses working in the same position as the defendant nurse.

She has served as a staff nurse, staff educator, nurse manager and director of women's and children's services for a hospital system and has taught courses in emergency pediatric nursing.

However, because the family's nursing expert is not a physician she will not be allowed to give an expert opinion linking breaches in the standard of care by the patient's nurse to the profound brain trauma and neurological aftermath sustained by the infant.

The family's board-certified pediatric otolaryngologist can give such an opinion in this case.

COURT OF APPEALS OF TEXAS
August 24, 2012

After the tube is placed, the correct placement of the tube is to be assessed with at least two confirmatory measures such as listening to breath sounds, visualization of equal rise and fall of the chest and use of the CO_2 detector, all of which is to be documented by the nurse.

A reasonably prudent nurse is required to recognize the infant's critical assessment findings and initiate an emergency response immediately. The standard of care for severe airway obstruction in children requires that practitioners call early for advanced help.

The hospital has the responsibility to provide properly trained and experienced PICU nurses with advanced pediatric life support training to care for the patient.

The hospital PICU must provide equipment such as suction catheters, tracheal intubation supplies, endotracheal tubes of all sizes and when a patient has a fresh tracheostomy a replacement trache tube of the same size and one size smaller must be kept at the beside.

Physician's Expert Opinion
Standard of Care

The family's board certified otolaryngologist added that the risk of accidental dislodgement of a fresh trache tube must be anticipated. Patient care must be arranged in such a way as to minimize such risk.

Staff caring for a pediatric trache patient should have a care plan for close monitoring of the patient and immediate recognition of accidental dislodgement and initiation of action to secure the airway.

All available professional help should be mobilized immediately when a trache tube becomes displaced or obstructed, including contact by the nurse with the attending physician and the surgeon who placed the trache tube.

A trache tube should never be bag ventilated unless the tube has been confirmed to be in the trachea.

The physician faulted the nurse for a significant delay from when the problem was first noticed until the code was called, that delay being the likely cause of the infant's profound brain damage. **Rio Grande Reg. Hosp. v. Ayala, 2012 WL 3637368 (Tex. App., August 24, 2012).**

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For the Nursing Profession

Correctional Nursing: Competent Care Was Provided, Nurse Dismissed From Lawsuit.

The inmate worked at a local hardware store on work-release but still lived in the jail.

After he complained to the jail nurse about nausea, vomiting, diarrhea and weakness he was sent to a nearby university hospital for evaluation. An EGD scope procedure was scheduled for two weeks later.

The nurse in the jail made the arrangements for the inmate to be transported back to the hospital for his procedure. The inmate, however, sent a communication to the jail warden stating that he did not want to have the procedure and would get it done on his own after he was released from the jail several months later.

The nurse explained to the inmate the nature of and reason for the procedure and urged him to follow through with it right away, but the inmate still insisted he did not want it. The nurse had the patient sign a refusal of medical treatment form which expressly released the sheriff's department, the jail and jail personnel from legal liability for his decision to refuse treatment.

Nine days later the patient was back in the infirmary to see the nurse, this time for stomach cramps and vomiting clear liquid.

Seven weeks after that the nurse saw him for chest pains. The nurse got an EKG, drew blood, sent the blood to the hospital lab and had the inmate seen by the physician.

The physician saw him and scheduled a follow-up appointment one month later.

Three weeks later the nurse saw him again. This time the patient reported for the first time that he was experiencing weight loss.

The nurse had him transported to the university hospital where he was diagnosed with colon cancer that by this time had metastasized to other organs. The patient was discharged to hospice care and died three months later.

The US Court of Appeals for the Fifth Circuit (Louisiana) dismissed the family's lawsuit.

The nurse's care was competent in all respects. After the inmate went against the nurse's advice and refused the indicated diagnostic intervention, apparently being afraid he might lose his slot in work-release, the nurse paid due attention to the signs and symptoms he saw and could not have known the patient's condition was actually life threatening. **Bedingfield v. Deen, 2012 WL 3868959 (5th Cir., September 6, 2012).**

Skin Care: Court Says Nurse Is An Expert On The Standard Of Care, Patient's Case Goes Forward.

The sixty-one year-old patient spent more than two months in the hospital recovering from multiple gunshot wounds. He had no less than seventeen open abdominal procedures and other surgeries for his leg wounds.

During his stay areas of skin breakdown started on his back, foot, coccyx, thigh, ankle, elbow and ear and progressed to Stages II and III.

In response to his lawsuit against the hospital alleging nursing negligence the hospital provided the court with an affidavit from a board-certified internist with additional qualifications in geriatrics who reviewed the medical records and concluded that the patient's skin breakdown and the progression of his lesions were inevitable consequences of his critical condition and impaired circulatory and respiratory status.

The lower court was wrong to disregard the patient's nursing expert's testimony.

She is knowledgeable about the standard of care required of nurses and other hospital personnel to try to prevent bedsores from progressing to serious skin lesions as the patient's bedsores apparently did.

Her testimony will assist the jury to reach a fair evaluation of the case.

CALIFORNIA COURT OF APPEAL
September 19, 2012

The California Court of Appeal ruled the case should not have been dismissed solely on the basis of the internist's opinion, without considering the opinion of the patient's expert nurse whose opinion the lower court discounted out of hand because she was a nurse and not a physician.

The patient's nursing expert stated that the progression of the lesions could be demonstrated by photos placed in the chart during his stay, but there were significant gaps in the nursing documentation of formulation of a care plan, review and modification of the nursing care plan and actual nursing interventions being performed. For some of the lesions shown in the photos there was no nursing documentation in the chart of any nursing care being given. **Aguayo v. St Francis Med. Ctr., 2012 WL 4098972 (Cal. App., September 19, 2102).**