LEGAL EAGLE EYE NEWSLETTER

September 2004 *For the Nursing Profession* Volume 12 Number 9

Positional Asphyxia: Patient Strangled In Restraints, Court Lets Lawsuit Go Forward.

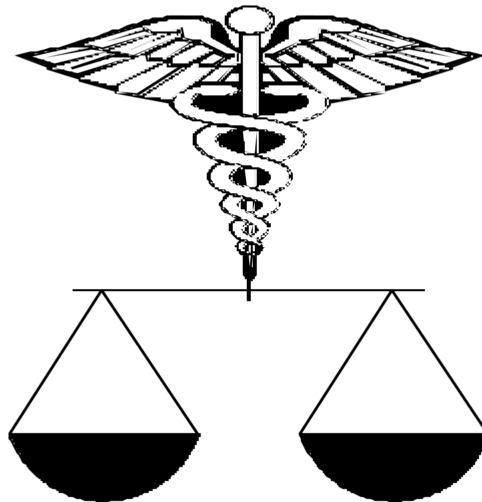
The deceased nursing home resident had suffered from multi-infarct dementia and diabetes.

She was a total care patient, requiring assistance with locomotion, dressing, eating, toileting and bathing. In addition, her dementia impaired her judgment and reasoning ability. She had no control over her locomotive skills and was prone to sliding in one direction or another in bed.

According to the Supreme Court of Michigan, she was at risk for suffocation by positional asphyxia.

The nursing home's medical director authorized use of various physical restraints including the bed rails and a restraining vest that kept her from moving her arms, both of which were intended to impede her ability to slide out of position. There were also wedges or bumper pads ordered to be placed on the outer edges of the mattress to keep her from hurting herself by sliding down or entangling herself in the bed rails.

As the court pointed out, state and Federal regulations require that use of restraints of this type must be authorized by a physician. The rationale of the regulations, rather than patient safety, is to prevent overuse of restraints and excessive confinement.



The day before the resident was asphyxiated two aides found her tangled in her bedding, clothing and restraints and close to strangling herself in the bed rails.

The aides informed their supervisor of the problem, but despite this knowledge nothing was done to rectify the situation. That would amount to negligence.

SUPREME COURT OF MICHIGAN
July 30, 2004

Resident Found Tangled No Corrective Action

The day before the resident's tragic death two aides found her lying in her bed very close to the bed rails tangled in her restraining vest, gown and bed sheets. The aides untangled her and repositioned her. They repositioned the wedges to try to keep the resident from slipping into the gap that existed between the mattress and the bed rails.

The aides would later testify in court that they informed their nursing supervisor of the situation. They specifically told the nursing supervisor that the wedges were not staying put but instead were able to slide to the side. They were concerned if better care were not taken the patient could be hurt or even fatally injure herself.

The next day the resident was found to have slipped between the bed rails and the mattress. The lower part of her body was on the floor but her neck was wedged in the gap between the bed rail and the mattress.

She was not breathing and had to be rushed to a hospital. She never recovered. Two days later she was taken off life support and allowed to expire. The family sued the facility seeking damages for wrongful death.

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Constipation/Impaction: Nurses Failed To Report Significant Change In Health Status. Punitive Damages Upheld.

A family member found the resident unconscious, slumped over in her wheelchair with foul smelling white foam coming out of her mouth, while two nurses aides were making her bed.

He had her taken to the hospital where surgery was performed to clean out her intestines from a fecal impaction. The surgeon testified it was the worst case he had ever seen.

Unfortunately after two more such surgeries she died of multi-organ failure secondary to sepsis from a perforated bowel. The condition had been there, in the surgeon's opinion, at least 48 hours before the surgeries were started.

The family sued. The jury awarded $500,000 compensatory damages and $5,000,000 punitive damages. The US Circuit Court of Appeals for the Eighth Circuit ruled that the nurses' conduct was so outrageous that punitive damages were appropriate, although $2,000,000 was ruled a more reasonable figure.

Significant Change In Health Status Duty To Notify The Physician

Although elderly nursing home residents are highly susceptible to constipation, constipation lasting more than three days for this resident would be considered a significant change in health status requiring a physician consultation. The physician had written express orders for impaction checks q 3 days.

In fact, in this case, the nursing staff started doing impaction checks after four days, were not able to obtain a bowel movement as a result and then stopped doing the checks five days into the resident's final bout of constipation. They did not call the physician or do anything further while the resident complained of severe pain and her abdomen swelled to the point she had to be hospitalized. **<u>Stogsdill v. Healthmark Partners, L.L.C.</u>, __ F. 3d __, 2004 WL 1636426 (8th Cir., July 23, 2004).**

The standard of care for a nursing home requires a resident's treating physician to be notified of a significant change in the resident's condition.

The resident's physician's standing orders included an impaction check every three days, an enema when necessary and milk of magnesia as needed, due to degenerative muscle disease and COPD which made her immobile and highly prone to constipation.

Three days without a bowel movement would be a significant change in health condition for this resident, that is, an event which required the physician to be notified so the nursing staff could obtain further orders.

When a family member complained after eight days without a bowel movement her nurse said they do not call the doctor every time somebody gets a bellyache.

The jury awarded $5 million punitive damages, which should be reduced to $2 million.

UNITED STATES COURT OF APPEALS
EIGHTH CIRCUIT
July 23, 2004

Post-Surgical Care: Nursing Home Found At Fault.

An eighty-one year-old stroke victim had to have an outpatient surgical procedure to incise and drain a skin lesion on his chest.

After the procedure he was returned to the long-term care facility with sterile packing in the partially-sutured incision site. The packing was to be removed after three days and the wound was to be covered with a dry dressing thereafter.

The man was back at the facility no more than five hours before bleeding was observed at the incision site. He was taken to the hospital by ambulance where he died the next day.

Even though the risk of complications was actually quite small, the resident should have been checked by a licensed nurse at least every one to two hours post surgery.

COMMONWEALTH COURT
OF PENNSYLVANIA
July 28, 2004

The Commonwealth Court of Pennsylvania upheld a civil monetary penalty along with downgrading of the facility's license to provisional status.

For over five hours licensed and non-licensed personnel were in and out of his room and non-licensed personnel took him to the dining room for his lunch.

No licensed nurse examined his dressing until an aide noticed he was bleeding through his bed sheets, which the court believed fell below the standard of care for caring for such a patient. It was not proven that the bleeding did not start right before it was noticed, but still his care was substandard, the court ruled. **<u>Manorcare Health Services-Lansdale v. Dept. of Health</u>, __ A. 2d __, 2004 WL 1672555 (Pa. Cmwlth., July 28, 2004).**

Guardianship Imposed: Nursing Home Not At Fault.

The patient was involuntarily committed for short-term psychiatric observation and a legal guardian was appointed against her will to take control of her affairs upon her return to the nursing home where she had been residing.

After she returned to the nursing home she filed a complicated lawsuit against the nursing home, her physician, the county mental health professionals and the psych hospital where she was taken.

No False Statements
No Legal Liability

The California Court of Appeal, in an unpublished opinion, ruled the nursing home was immune from a lawsuit unless its staff made false statements in support of the plan to institutionalize the patient.

The nursing home staff phoned the patient's doctor and told her she was attempting to wheel herself out of the facility. The doctor took it from there, calling the mental health authorities. The nursing home acted properly in all respects, the court said. **Skobin v. County of Los Angeles, 2004 WL 1843310 (Cal. App., August 18, 2004).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924

© 2004 Legal Eagle Eye Newsletter

Indexed in
Cumulative Index to Nursing & Allied Health Literature™

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

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Excessive Force Alleged: Court Clears Psych Nurse.

If the nurse had twisted the patient's arm, forcibly pushed him to the time-out area and slammed him against the wall while he got out his key and unlocked the door, that would have been excessive force.

The medical evidence fails to support any claim the patient had any injury to his arm or shoulder, let alone that an injury resulted from excessive force.

When an angry and agitated psychiatric patient acts out aggressively in a group setting it is appropriate for the nurse to de-escalate the situation. The nurse can take the patient by the arm and escort the patient to a secure area for some time out, in the interest of protecting patients and other staff.

CALIFORNIA COURT OF APPEAL
UNPUBLISHED OPINION
August 11, 2004

The patient had been diagnosed as a paranoid schizophrenic. He went to one hospital to obtain his medical records and threatened a nurse when she told him they did not have them. As a result he was taken to another hospital for a 72 hour involuntary psych hold.

In that hospital's ICU a phlebotomist was trying to draw blood to assay his medication levels. A psych nurse came in to assist. For the previous two days the patient had been verbally abusive toward the same psych nurse. This time he spit in the nurse's face.

To calm him down and to protect other patients and staff the psych nurse placed one arm under his elbow and put his other elbow under the patient's biceps and walked him to a quiet area to calm down. He had to hold the patient against the wall while getting out his key to unlock the quiet area.

Patient Was A Threat To Others

The phlebotomist later testified she was glad the nurse intervened as she felt threatened by the patient's behavior and believed he was a potential threat to other patients standing by to have blood drawn.

The California Court of Appeal, in an unpublished opinion, threw out the patient's claim of excessive force alleged in his lawsuit filed against the nurse and his own psychiatrist. **Gregovich v. Berger, 2004 WL 1784749 (Cal. App., August 11, 2004).**

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Failure To Report Child Abuse: Nurse Faulted In Child's Death.

A hospital nurse was charged with the criminal offense of failure to report child abuse. Her lawyers argued in her defense that she could not be prosecuted because the state criminal statute is unconstitutionally vague. The Supreme Court of Missouri took jurisdiction of the case to rule on the Constitutional issue.

The court noted that the "reasonable cause to suspect" or "reasonable cause to believe" language in mandatory child-abuse reporting statutes in Texas, Minnesota, Michigan and Wisconsin has been expressly ruled not unconstitutional, and upheld Missouri's law.

Health care personnel are expected to know what reasonable cause to suspect or to believe evidence of child abuse exists means without further explanation by the legal system, the court ruled.

Evidence of Abusive Head Trauma
No Report Filed

Fire and rescue personnel were summoned to the home where a two year-old was in foster care. They found him unconscious, not breathing and posturing, which the court pointed out is an abnormal rigidity of the body which indicates serious brain damage has occurred. They also found a series of bruises running parallel along his spine and a red bruise under his eye. They transported him to the hospital.

All their findings were relayed to the nurse at the hospital. However, the child was treated and released. He was returned two days later and died at the hospital from abusive head trauma.

The nurse admitted she was aware of her legal obligation to report child abuse and knew there was a phone hotline for reaching the proper child-welfare authorities.

She also admitted she had elected not to document the trauma to the child in her nursing notes, which likely would have alerted a physician or other hospital caregiver to make a report, a violation of her own duty to report abuse to the physician in charge as well as to child welfare authorities. **State v. Brown, __ S.W. 3d __, 2004 WL 1729445 (Mo., August 3, 2004).**

Any physician, nurse, hospital or clinic personnel involved in the examination, care, or treatment of children or persons with responsibility for the care of children, who has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or who observes a child being subjected to conditions or circumstances which could reasonably result in abuse or neglect must immediately report or cause a report to be made to the division of family services.

Reasonable cause to suspect or reasonable cause to believe is the operative language, as that is what sets in motion the health care provider's legal duty.

As a general rule it is a violation of the Constitutional right to Due Process of Law to prosecute someone for a criminal act that is so vaguely defined in the law that someone would not know they are committing a violation.

Courts in other states that have had to rule on the issue have found the "reasonable cause" language not unconstitutionally vague.

SUPREME COURT OF MISSOURI
August 3, 2004

Removal Of Dentures: Court Declines To Fault Nurses.

The elderly patient was admitted to the hospital for surgery on his foot ulcers. He was noted to be suffering from severe senile dementia.

Prior to the procedure the nurses doing the prep tried to remove his dentures. When they encountered difficulty they went to talk to the patient's son in the waiting room. The son advised the nurse his father did not have dentures. He went in to find out what was going on.

The son observed one nurse holding his father's shoulders down while a second nurse was tugging at his mouth, while his father was moaning. He told them his father's teeth did not come out.

After the surgery his teeth, actually a fixed partial denture that had a dentist had cemented in place, were cracked and hanging loosely in his mouth.

The son sued the hospital as probate administrator on his father's behalf.

A nurse can testify regarding the nursing standard of care. A nurse cannot offer an expert opinion as to the cause of the patient's dental injuries.

COURT OF APPEALS OF OHIO
July 29, 2004

While not endorsing what happened the Court of Appeals of Ohio had to rule in the hospital's favor.

The son's lawyer's nursing expert could testify it was wrong for the nurses not to have known or ascertained that the patient's dentures did not come out. However, she was not qualified to testify as to the cause of the dental damage observed after the surgery. The patient's dentist, although qualified to testify, had not examined patient. **Hager v. Fairview General Hosp., 2004 Ohio 3959, 2004 WL 1688537 (Ohio App., July 29, 2004).**

Positional Asphyxia: Patient Strangled In Restraints, Court Lets Lawsuit Go Forward.

(Continued from page 1)

The family's case was thrown out by the lower state courts.

The grounds were that it was not a case of ordinary negligence but was a medical malpractice case, and because by the time the family could re-file the case as a medical malpractice case to comply with the judge's ruling that it was a medical malpractice case, the statute of limitations for medical malpractice had already lapsed.

The Michigan Supreme Court sent the case back to the lower court for jury trial.

Nursing Supervisor Was Notified Omission To Act Was Ordinary Negligence

The simplest rationale the Michigan Supreme Court could find to allow the case to proceed was that it does not take a medical expert to allow the jury to conclude that the nursing supervisor was negligent for not taking action when the two aides informed her of the problem.

The nursing supervisor's inaction in the face of an obvious hazard to a resident under her care was ordinary negligence. The lower courts were wrong to see it as malpractice and there was no issue with the statute of limitations.

Care Plan Did Require Expertise Malpractice Seen

The court pointed out that even the simplest act of putting a dementia patient to bed requires a great deal of specialized professional expertise.

The Michigan Supreme Court recognized the family's expert witness as a true expert in this field by pointing to his co-authorship of *Deaths caused by bed rails,* 45 J Am Geriac Soc 797 (1997).

That journal article criticized the widespread use of bed rails without a clear sense of their role in the treatment plan and called for nursing homes to limit the use of bed rails out of concern for patients' safety.

However, in this particular case it would be for the jury to consider all of the evidence before deciding whether the combination of restraints, bedding materials, clothing, bed rails and the mattress fell below the professional standard of care for nursing personnel.

The court also saw an ongoing need for professional nursing and medical staff to re-assess and re-evaluate their patients as time goes on to be sure that the combination of restraints, bed rails and other materials is meeting their needs and not posing a safety hazard.

Staff Training Ability to Recognize Hazard

The court discussed in general terms the obligation of nursing facilities to train their staff to appreciate the risk to dementia patients and other residents of positional asphyxia in the gap between the bed rails and the mattress in combination with restraints, bedding and clothing.

That will likely be a moot point in this case as it was the aides who brought the problem to their supervisor's attention, rather than the other way around.

Duty to Ensure Safe Environment

The court pointed to language in state and Federal regulations for long-term care which requires facilities to ensure that residents have an accident-free environment.

As other courts have done, the Supreme Court of Michigan declined to interpret the word "ensure" to mean that a nursing facility is strictly or automatically liable any time any accident happens to a resident. The family's lawsuit was ruled improper to the extent it relied on that erroneous interpretation of this language in the Federal regulations.

Instead, this language is only a statement of public policy that nursing facilities are expected to take all practicable measures for patient safety. Facilities will continue to be judged by the rules of negligence rather than strict liability in nursing-home accident cases, as far as this court is concerned. **Bryant v. Oakpointe Villa Nursing Centre, __ N.W. 2d __, 2004 WL 1724901 (Mich., July 30, 2004).**

The courts have been struggling to decide whether cases like this are better characterized as medical malpractice or ordinary negligence.

Medical malpractice requires proof through the testimony of a properly qualified expert witness. The family has at least one such witness on their side.

However, medical malpractice has a shorter statute of limitations than ordinary negligence.

If this is a medical malpractice case rather than an ordinary negligence case it has to be dismissed out of hand because the medical malpractice allegations were first raised more than two year after the patient's death.

Because of the confusion that has to this point existed in the courts as to how these nursing-home accident cases are to be characterized, it would not be fair to throw out this case even though many of the allegations raised by the family are for medical malpractice and were first filed after the statute of limitations to sue for malpractice had run out.

SUPREME COURT OF MICHIGAN
July 30, 2004

IV Therapy: Lawsuit Alleges Complications From Too Rapid Infusion Rate.

In any healthcare malpractice lawsuit, the patient or person suing on the patient's behalf must prove to a reasonable degree of medical certainty that negligence by the healthcare professional caused harm to the patient.

In this case the patient's home health nurse allowed the patient's IVIg to infuse at a rate which exceeded the manufacturer's recommendations, which exceeded the pharmacist's directions and which exceeded the nurse's own experience with the patient gradually increasing the flow rate to test the patient's tolerance.

Rapid Infusion Followed By Stroke

The day after the rapid infusion the patient suffered a stroke, a non-hemorrhagic infarction of the right middle cerebral artery.

Manufacturer Warned of Stroke As Complication

The manufacturer had circulated a product insert identifying rapid infusion of IVIg as a risk factor in vascular occlusive events.

However, as pointed out by the Court of Appeals of Minnesota, the extensive clinical investigation of an extensive list of post-infusion complications had never conclusively linked the drug to a cerebral vascular occlusive event. Therefore, because the medical literature is inconclusive on this point, the court ruled the patient's expert neurologist had no solid basis to testify with the legally-required reasonably degree of medical certainty that the nurse's actions caused the patient's stroke.

Court Sees No Solid Proof Of Causation Case Must Be Dismissed

Without such testimony there was a critical break in the chain of proof necessary to sustain the patient's case and the case had to be dismissed. Just pointing to a possible risk that happens to materialize is not exact enough to sustain a malpractice lawsuit. **McDonough v. Allina Health System, (Minn. App., August 17, 2004).**

The lawsuit alleged the home-health nurse allowed the patient's IV to infuse at a rate that exceeded the pharmacist's directions and the drug manufacturer's recommendations.

The pharmacist's directions were to start the IV at a relatively low rate and to increase the flow rate at fifteen minute intervals to test the patient's tolerance.

The patient had experienced chills when the IV reached 125 ml/hr, so the nurse slowed the flow rate and called the pharmacist. With Tylenol for the chills the patient seemed to tolerate the slower flow rate.

The next day the nurse infused the IV very rapidly, reaching a flow rate that was calculated after the fact to have reached 800 ml/hr for a brief interval.

The patient had a stroke. The manufacturer's insert had warned of the risk of stroke from too rapid infusion of this drug.

However, the medical literature is inconclusive that the drug has ever actually caused a stroke, so the patient's case against the nurse must fail.

COURT OF APPEALS OF MINNESOTA
August 17, 2004

Gynecological Surgery: No Proof Linking Nursing Care To Patient's Stroke.

Before her hysterectomy her physician went through the standard informed-consent protocol with the patient which included advising the patient there was a risk of stroke.

Two days after her surgery the patient's nurse found she could not understand her speech and promptly notified the doctor who came in twenty minutes later at 2:20 a.m. He found her neuro status intact. He and the nurses continued to follow her closely the next day, noting that she was able to communicate and move all her extremities and had normal and symmetrical grip strength in her hands.

She did have a second bout of confusion and difficulty speaking, which resolved. She was discharged in apparently stable condition. Later it was determined she had had a stroke while in the hospital.

The patient apparently suffered a stroke while under the nurses' care recovering in the hospital after her hysterectomy.

All relevant signs were seen and noted by the nurses and the physician.

There is no proof linking the stroke to any lapse in the patient's nursing care.

NORTH CAROLINA COURT OF APPEALS
UNPUBLISHED OPINION
August 17, 2004

The North Carolina Court of Appeals could find nothing wrong with her nursing care or anything even to suggest it somehow caused her to have a stroke, and ordered dismissal of the case. **Bak v. Cumberland Co. Hosp., 2004 WL 1824303 (N.C. App., August 17, 2004).**

Home Health: Work Comp Covers Workers Coming And Going To Assignments.

A home health aide was struck by a car crossing the street in front of her apartment to catch the bus to travel to the home of one of her employer's clients.

Her workers compensation claim was denied based on the accepted rule that injuries on public rights of way while commuting to and from work are not covered by workers comp.

Ordinarily an injury sustained by an employee on a public street or highway while the employee is going to or coming home from work is not eligible for workers compensation.

One exception, however, is a job where the employee must travel from one place to another as part of the job itself. A home health worker's job fits within this exception.

APPELLATE COURT OF CONNECTICUT
August 3, 2004

The Appellate Court of Connecticut ruled she was entitled to compensation. A home health worker's job necessarily involves travel to and from clients' homes as part of the job itself.

The court said it is not important if the worker is going to the first assignment of the day, back home from the last or in between assignments. It is also not relevant if the employer reimburses the employee for travel expenses. **Labadie v. Norwalk Rehab. Services, Inc., __ A. 2d __, 2004 WL 1732181 (Conn. App., August 3, 2004).**

Labor And Delivery: Court Says Nursing Understaffing Is Valid Grounds For Lawsuit.

The rules of evidence impose an important gatekeeping function on the trial judge with regard to the admissibility of expert opinions.

Expert testimony is admissible only if it is reliable.

The court must determine if the expert is qualified by knowledge, skill, experience, training or education to state an expert opinion.

The court must also look at the facts underlying the expert's opinion, the expert's methodology and the strength of the link between the facts and the conclusions the expert has drawn.

The patients' nursing expert looked at the mother's and child's medical records, the depositions of all of the physicians and nurses involved in the patients' care, the nursing patient assignment lists, the birthroom records for the other patient the patients' nurse was attending to, the hospital's nursing policies and the accepted Perinatal Guidelines and publications from the Association of Women's Health, Obstetric and Perinatal Nurses.

UNITED STATES DISTRICT COURT
KANSAS
July 19, 2004

The child was delivered by emergency cesarean twenty-four hours after the mother was admitted and began elective induction of labor. The child has permanent brain damage related to birth hypoxia. The mother's uterus was ruptured and her bladder, cervix and vagina were severely lacerated.

A lawsuit was filed against the hospital on the mother's and child's behalf.

At this stage of the litigation the US District Court for the District of Kansas has not made a definitive ruling on the hospital's liability. The court has ruled only that the hospital is not entitled to dismissal of the case on the grounds that the patients' nursing expert is not qualified to render an expert opinion. That leaves it for a civil jury to hear all the expert medical and nursing testimony and to render an ultimate decision.

Substandard Nursing Care
Nursing Understaffing

The court ruled the patients' nursing expert had the qualifications and had examined all the relevant facts to reach an opinion how the hospital was negligent.

The nursing expert found fault with a lack of one-on-one care during critical phases of the mother's labor. The expert also criticized the fact there was no continuity of care for the mother during her labor, that is, there was frequent shifting and sharing of nursing responsibility.

The expert could point to the care another patient was getting from the mother's nurse at the exact moments the fetal monitor showed she should have been attended to by a nurse who should have notified her physician what was going on.

Apparently the pitocin was continued, at a high rate of flow, despite warnings from the fetal monitor of ominous late decelerations. In the nursing expert's opinion that was substandard care caused or compounded by understaffing. **Holt. v. Wesley Medical Center, LLC, 2004 WL 1636571 (D. Kan., July 19, 2004).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Budgetary Issues: Court Says Partner, Corporate Officer Can Be Held Liable For Substandard Patient Care.

The nursing home was owned by a limited partnership. The limited partners in a limited partnership are not personally responsible for negligent acts or omissions by personnel employed by the limited partnership.

Every limited partnership must have at least one general partner responsible for operation of the partnership business. The general partner can be held liable for errors or omissions by persons employed by the limited partnership to carry out the partnership's business.

In this case the managing partner in the partnership was a corporation. In general, the stockholders and officers of a corporation are not personally responsible for negligent acts or omissions committed by corporate personnel.

All that being said, the District Court of Appeal of Florida ruled there were grounds for a deceased resident's family to sue the principal businessman who had set up the whole arrangement when he purchased the nursing home.

The principal was the sole member of the governing body of the nursing home required by Federal regulations (42 CFR 483.75(d)) to make and implement patient-care policies.

Even if corporation law shielded him from personal liability, the long-term care regulations would not shield him, the court believed.

The court said he apparently ignored complaints of inadequate staffing while cutting operating expenses. The deceased resident's family alleged in their lawsuit that the resident suffered from pressure sores, infections, poor hygiene, malnutrition and dehydration as a direct result of understaffing.

The court ruled that the jury was entitled to find, if the evidence supported that conclusion, that the principal was negligent and could be found civilly liable for valuing profit over patient care. **Estate of Canavan v. National Healthcare Corp., __ So. 2d __, 29 Fla. L. Weekly D1705, 2004 WL 1635000 (Fla. App., July 23, 2004).**

Nurse Failed To Control Unruly Children In E.R. Waiting Room: Hospital Can Be Held Liable.

A mother arrived in the emergency room accompanied by her six children. When she and the child who needed medical attention went into a treatment cubicle the other children were left alone in the waiting room.

According to the New York Supreme Court, Appellate Division, the unsupervised children were horseplaying, running around and climbing on the beds.

An E.R. nurse more than once instructed the children to stop running. Nevertheless one of the children, about five hears old, accidentally ran into a fifteen month-old toddler whose mother had brought him to the E.R. and was waiting to be seen, knocking him down and causing him to break his arm. His mother sued the hospital on his behalf.

A hospital has a duty to protect its patients from injury. In general, any business owner must maintain the premises in a reasonably safe condition for the benefit of its patrons.

The nurse knew the unruly children were a hazard but did not take reasonable steps to control them for the benefit of other persons who might be injured by their horseplay.

NEW YORK SUPREME COURT
APPELLATE DIVISION
August 5, 2004

The court ruled the nurse should have appreciated the hazard to other patients and done more to control them, such as calling hospital security or moving the fifteen month-old somewhere where he would be safer.

The direct import of the court's ruling was only to send the case back to the lower court for a jury trial to determine whether the nurse was negligent, given the nature of the situation and the resource options available to her.

The court said the hospital had no parental responsibility toward the one mother's other five children, but rather had a business owner's general responsibility to make its premises safe for its patrons from known hazards. **Rodriguez v. 1201 Realty LLC, 2004 N.Y. Slip Op. 06300, 2004 WL 1746329 (N.Y. App., August 5, 2004).**