LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

September 2006 Volume 14 Number 9

EMTALA Violation: Hospital's Procedures Not Followed, Patient Discouraged From Staying.

Two hours after a minor motor vehicle accident a woman thirty-eight weeks pregnant was advised by phone by her ob/gyn's partner to go to the nearest E.R. because her contractions were increasing in frequency.

Her husband drove her to the nearest hospital. E.R. personnel told her, since her ob/gyn did not practice there, that hospital personnel had to phone the on-call ob/gyn to see if he would come in and see her. Rather than wait, she and her husband drove forty miles to another hospital where she was seen and released. A week later she had a normal delivery of a healthy baby.

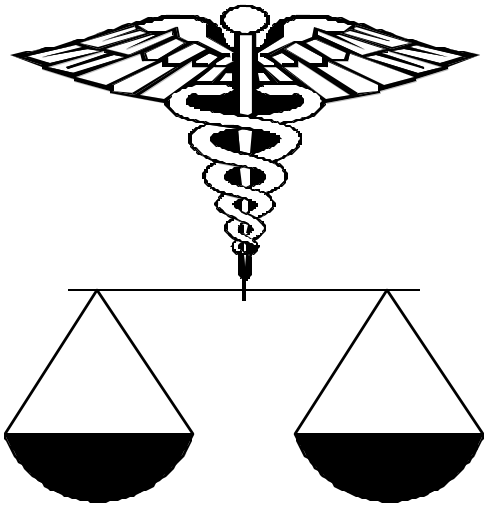
EMTALA Violation

The patient sued the first hospital for violation of the US Emergency Medical Treatment and Active Labor Act (EMTALA) for compensation for the emotional distress she experienced during the forty-mile drive while her labor apparently was starting.

The US District Court for the Middle District of Alabama noted the EMTALA does let the patient sue for emotional distress even if there is no bodily harm or medical complications.

Standard Medical Screening Exam

The fundamental requirement of the EMTALA is that every person who comes to the E.R. must get the same medical screening examination and necessary stabilizing treatment as everyone else who presents at the hospital with the same emergent history, signs and symptoms.



A hospital meets its duty under the EMTALA to screen emergency patients by defining in advance the screening process for specific complaints and then applying the screening process uniformly.

Necessary stabilizing treatment for emergent conditions found during screening must also be provided uniformly.

UNITED STATES DISTRICT COURT
ALABAMA
August 14, 2006

This hospital's written policy was that any patient twenty or more weeks pregnant who had been in a motor vehicle accident was to be seen immediately by the E.R. physician and the E.R. physician was to phone the on-call ob/gyn for orders how to treat the patient on the spot.

The hospital's standing policy was clearly ignored, a basic violation of the EMTALA, the court ruled.

Patient Was Unduly Discouraged From Remaining for Treatment

Reasonable delay is permitted for E.R. patient registration. It was not an issue in this case, but screening and treatment cannot be held up while insurance coverage is verified during the registration process.

The EMTALA prohibits any delay tending to discourage the patient from staying. Some courts have required E.R. personnel to encourage patients to stay. This court said the business about having to contact the on-call the ob/gyn before they could say the patient could be seen violated the EMTALA's original purpose of keeping hospital E.R.'s from "dumping" patients on other hospitals. **Henderson v. Medical Center Enterprise, 2006 WL 2355467 (M.D. Ala., August 14, 2006).**

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Informed Consent: Patient Has A Right To Know Extent Of Student Participation.

The patient was to undergo fundoplication surgery to repair an esophageal hernia. The procedure involves insertion of an esophageal dilator, which at this hospital is done by the anesthesia team at the surgeon's direction.

In this case the dilator was to be inserted by an RN in training to become a certified registered nurse anesthetist (CRNA).

The RN introduced herself to the patient right before the procedure. She introduced herself by her first name only and said only that she was a registered nurse who would be working with the nurse anesthetist and anesthesiologist. She referred to the nurse anesthetist by her first and last names and to the anesthesiologist by the title "Doctor" and his last name.

The RN tore the lining of the esophagus attempting to insert the dilator. The patient's abdomen had to be opened intra-operatively to repair the damage and that more-invasive-than-expected turn of events led to serious complications.

The Court of Appeals of Ohio upheld the patient's right to sue.

Lack of Informed Consent

A patient has the right to be fully informed and to give or to withhold consent to any medical procedure.

A patient has the right to be fully informed of the complete extent of any anticipated student participation and the right to refuse to consent to student participation. The same is true of any research or data collection expected to be associated with the patient's procedure.

Improper Supervision

The court also pointed out that a CRNA must be supervised by an anesthesiologist. In this case the RN was only being supervised by the CRNA at the moment she put in the dilator. The court ruled that is below the standard of care as defined by nationally accepted standards and this hospital's own internal policies. **Luettke v. St. Vincent Mercy Med. Ctr., 2006 WL 2105049 (Ohio App., July 28, 2006).**

The legal standard of care requires patients to be informed of the identities of all the individuals who will be involved with their care. That means patients must be told exactly who will actually be doing what and who will be standing by to supervise or consult.

Properly identifying these individuals includes giving their names, occupations and job titles and identifying the healthcare or educational institutions or professional corporations with whom they are associated.

Patients are entitled to be informed of the identity and training status of any student caregivers who will be involved in their care.

That means if a student will be the one with hands on for a particular task, the patient has the right to know.

Fundamental to the right to give informed consent, of course, is the right to refuse consent if the patient is not willing to allow a student, or for that matter any other individual, to be involved whom the patient does not want involved.

COURT OF APPEALS OF OHIO
July 28, 2006

Lasik Eye Surgery: Nurse Did Obtain Informed Consent From The Patient.

The patient sued her physician claiming she had blurred vision, light sensitivity, glare, halos and starbursts following Lasik vision-correction surgery.

The patient's lawsuit tried to point the finger of blame at the physician's nurse who was in charge of patient-consent forms in the physician's clinic.

As a general rule, to give truly informed consent the patient must have been informed of the alternatives to the proposed procedure.

The nurse did not discuss radial keratotomy or a clear lensectomy with the patient.

However, the physician had determined the patient was not a viable candidate for either of those procedures.

UNITED STATES DISTRICT COURT
NEW JERSEY
August 2, 2006

The US District Court for the District of New Jersey upheld the jury's verdict exonerating the nurse and her employer.

The nurse explained and made sure the patient read and initialed each page and signed the last page of the standard patient-consent form from the laser equipment maker which fully advised the patient of the side effects that happened to occur. It was irrelevant that alternative procedures unsuited to the patient were not discussed with her. **Hinman v. Russo, 2006 WL 2226333 (D.N.J., August 2, 2006).**

Decubitus Ulcer: Facility Found Liable, Patient's Legal Case Supported By The Inadequacy Of The Nursing Documentation.

The elderly patient was admitted to the hospital's ICU with septic shock and adult respiratory distress syndrome. He was sedated, given a paralytic and put on a ventilator. After a while he developed a serious decubitus ulcer on his tailbone.

Four weeks later, after his condition had markedly improved, he was transferred to a rehab facility. In rehab he developed decubitus ulcers on his heels.

Two months later he was transferred from rehab to a VA hospital for treatment of the same lesion still there on his tailbone. It healed after several months.

He sued the first hospital over the tailbone lesion. The Court of Appeals of Texas approved a $240,000 jury verdict in his favor.

Skin Integrity
Legal Standard of Care

The legal focus in pressure-sore cases is whether the development or progression of a skin lesion was avoidable, or was unavoidable because of the patient's medical condition despite caregivers being able to show that all necessary care and treatment for skin integrity was given to the patient.

The ICU records contained no documentation that the nurses carried out any interventions that would have prevented the pressure lesion from getting worse after it was discovered.

The physician should have been notified at once when a small skin tear on the tailbone was first seen. The physician was not told until the next day.

The physician ordered a wound-care nurse consult and a special bed. The only follow up to the physician's orders was the wound care nurse coming in three days later. By then they were dealing with a serious decubitus ulcer.

Further, there was no documentation that the wound-care nurse's orders had been transcribed into the care plan or were being implemented.

COURT OF APPEALS OF TEXAS
July 21, 2006

Nursing Standard of Care
Documentation Lacking

The court went over in detail and endorsed the testimony of the patient's nursing expert witness.

Skin assessment and pressure relief should be provided every two hours. Every two hours there should be documentation of pressure relief or a progress note that it was attempted but not performed.

Ways to provide pressure relief include turning the patient, or repositioning the patient with use of pillows or foam wedges to protect bony prominences if the patient will not tolerate a full turn.

If the patient cannot be turned, the nurses must fully document why. An example might be a drop in blood pressure or change in heart rate or difficulty breathing in a certain position. The purpose of such documentation is to communicate the patient's status to other members of the healthcare team, above and beyond its obvious importance if a lawsuit resulted.

Proper assessment of a wound includes a verbal description that will allow anyone reading it to draw a mental picture of exactly what the nurse saw. Charting should note color, location, size, depth, presence or absence of infection and whether tissue was dead or perfused.

Absence of documentation in the chart leads to only one conclusion, that care was not performed, and failure to provide care is negligence, the court said. **Columbia Medical Center v. Meier, __ S.W. 3d __, 2006 WL 2036574 (Tex. App., July 21, 2006).**

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Carpal Tunnel: Computer Data Entry Essential Function Of Nurse's Job.

A nurse practitioner's disability discrimination lawsuit focused on her carpal tunnel. For that condition her physician gave her a medical restriction against typing more than five hours per day or more than ten minutes at a time.

Her employer tried voice-recognition software as an accommodation but it would not recognize her voice. She was transferred from direct patient care to an office job which did not require as much keyboard typing, then to infection control, without any loss of pay or benefits.

The Americans With Disabilities Act requires employers to provide reasonable accommodation to the needs of disabled employees who are able to do their jobs satisfactorily with reasonable accommodation.

It would be an undue hardship for the employer, that is, it would not be a reasonable accommodation to have to provide a personal medical assistant for computer-data entry tasks.

UNITED STATES DISTRICT COURT
TENNESSEE
August 2, 2006

The US District Court for the Western District of Tennessee dismissed her lawsuit. Hiring her a personal medical assistant just to do her computer charting so that she could remain in direct patient care would impose an undue hardship on her employer. **Miller v. Principi, 2006 WL 2222682 (W.D., Tenn., August 2, 2006).**

Discrimination Case: Victim Cannot Break Medical Confidentiality.

A certified nurses aide filed a complaint with the US Equal Employment Opportunity Commission (EEOC) against her then-employer, a nursing home, for age and race discrimination.

During the EEOC's investigation she gave copies to the EEOC of confidential materials she copied from her and other aides' patients' charts to show that African-American aides were being disciplined differently than Caucasians for basically the same errors in patient charting. She had no permission from her employer or from the patients to do this

She was fired for violating patients' medical confidentiality.

The court finds it a truly remarkable proposition that a former employee would claim her former employer committed illegal retaliation by dismissing her for providing confidential information from patients' charts to the EEOC to support her discrimination claims.

UNITED STATES DISTRICT COURT
OKLAHOMA
August 4, 2006

The US District Court for the Western District of Oklahoma conceded that differential discipline for the same offense is a form of illegal discrimination and that retaliation against an employee for filing a complaint with the EEOC, regardless of the complaint's validity, is strictly illegal.

However, the court would not extend the principle to deny an employer's right to fire someone for unauthorized use of confidential patient data. **Vaughn v. Villa, 2006 WL 2246453 (W.D. Okla, August 4, 2006).**

Discrimination: Med Errors Are Grounds For Termination.

An African-American nurse was hired by a nursing home and, after a few days of orientation, was placed in the position of charge nurse. She was given the key to the locked medication cart and the key to the narcotics box locked within the locked medication cart.

Five days after being hired she was written up for a medication error, that is, a 2.5 cc discrepancy came up with the liquid morphine in the narcotics box.

The next day she was written up for showing poor nursing judgment for giving multiple prn medications to a patient which resulted in a decrease in level of consciousness and difficulty breathing which required the physician to be notified.

After being terminated she sued for racial discrimination.

When the employer has an apparently legitimate reason or reasons for terminating an employee, it is up to the employee to convince the court the employer's stated reasons are merely a pretext for an underlying discriminatory motivation.

UNITED STATES DISTRICT COURT
ARKANSAS
August 7, 2006

The US District Court for the Eastern District of Arkansas ruled the nurse employee was unable to come up with proof of any discriminatory motive behind her former employer firing her for two serious medication errors in two days during her first week on the job, and dismissed her discrimination case. **Johnson v. Oakdale Nursing Facility, 2006 WL 2311107 (E.D. Ark., August 7, 2006).**

Discrimination: Gratuities From Patients Are Grounds For Termination.

An African-American staff nurse was terminated for breaches of professional ethics.

It was documented that she had accepted gratuities from a patient on twenty separate occasions, had had repeated outside sexual contacts with the patient and had allowed a romantic relationship to develop which eventually led to a marriage proposal.

After her termination she sued for racial discrimination.

To prove discrimination a minority employee must be able to point to one or more non-minorities with the same work record who were treated more favorably.

UNITED STATES DISTRICT COURT
MISSISSIPPI
August 7, 2006

The US District Court for the Southern District of Mississippi pointed out the general rule in discrimination cases involving differential discipline is that the victim must be able to identify one or more non-minorities who were treated less harshly or more favorably for basically the same disciplinary infraction.

In fact, a Caucasian nurse at the same hospital some years earlier had dated and married a former patient. The Caucasian nurse's actions, the court said, were unprofessional but basically naive.

On the other hand, the court believed the nurse in question was systematically abusing and exploiting her patient, more seriously unethical and not comparable to the conduct of the other nurse. **Chambers v. Principi, 2006 WL 2255261 (S.D. Miss., August 7, 2006).**

Discrimination: Minority Must Point To Non-Minority As Basis For Comparison.

A male Caucasian certified nursing assistant was fired for patient abuse, that is, for abruptly dropping a nursing-home patient into her chair during a transfer from her bed and then pushing her hard on the forehead when she slumped forward in the chair.

He was reported to the state department of health, but the department's investigation concluded there were no grounds to charge him with abuse.

He sued for gender discrimination.

The employee bears the burden of proof that the employer's disciplinary action was merely a pretext for illegal discrimination.

UNITED STATES DISTRICT COURT
ARIZONA
August 10, 2006

The US District Court for the District of Arizona agreed that a male CNA would be considered a minority for purposes of discrimination law and further agreed in general terms that differential discipline of a male caregiver compared to one or more female caregivers amounts to illegal gender discrimination.

That being said, the court found the CNA's evidence of discrimination inconclusive. Merely saying that a female CNA was accused of abuse but not fired is not enough. The alleged victim must show that the detailed particulars of the non-minority's infraction were identical to his in all essential respects, or there is no valid basis for comparison. **Harwood v. Avalon Care Center, 2006 WL 2345906 (D. Ariz., August 10, 2006).**

Bosnian Male Nurse: Discrimination Claim Denied.

A man who had attended an accredited nursing school in the US and passed his nursing boards after emigrating from Bosnia was dismissed from a hospital staff nursing position before his six-month probationary period had expired.

He sued for gender and national-origin discrimination.

A male nurse is a minority for purposes of gender discrimination law.

Like any other alleged victim suing for employment discrimination he still must prove he was fully qualified for the job from which he was dismissed.

UNITED STATES DISTRICT COURT
NEW YORK
August 9, 2006

The US District Court for the Northern District of New York agreed a male nurse from Bosnia is considered a minority for two separate reasons.

However, during his probationary period there were seven documented patient-care errors. Two of them, giving a glass of water to an elderly man with aspiration problems and leaving a biohazard material tray on the floor in a patient's room, were serious threats to patient safety that would justify terminating even a tenured nurse.

Any probationary nurse, under the union contract, could be dismissed abruptly without progressive discipline if he was not meeting expectations.

Based on his performance record the court ruled he was not qualified for his job and thus not eligible to sue for discrimination. **Memisevich v. St. Elizabeth's Medical Center, __ F. Supp. 2d __, 2006 WL 2277964 (W.D.N.Y., August 9, 2006).**

Skilled Nursing: Multiple Violations Of Medicare Standards, Civil Monetary Penalties Upheld.

State survey inspectors came to a skilled nursing facility in response to complaints and found nine violations of Medicare standards.

They revisited the facility six weeks later and found the facility in substantial compliance.

A month later, however, during the facility's annual inspection, $77,100 in civil monetary penalties were levied for twenty-nine separate violations of Federal Medicare standards found in Title 42 of the US Code of Federal Regulations (42 CFR § 438.15 and § 438.25).

The facility's appeal was heard by the US Circuit Court of Appeals for the Sixth Circuit. The court upheld all twenty-nine penalties, but limited its discussion only to certain illustrative examples.

The skilled nursing facility argued in its defense that some of the residents were not actually harmed by the violations the state survey inspectors observed.

The facility's argument fails to recognize that actual harm is not required for survey inspectors to impose a civil monetary penalty.

A threat of more than minimal harm to a resident due to substandard compliance with Medicare-participation requirements is all that is necessary to justify imposing a penalty.

The amount of the daily penalty – from the time a deficiency in found until it is corrected – will vary depending on the severity of the specific harm which could potentially happen to a resident.

If actual harm does occur, the fact of actual harm and its severity are additional factors going to the amount of the civil monetary penalty commensurate with the violations in question.

UNITED STATES COURT OF APPEALS
SIXTH CIRCUIT
August 1, 2006

Social Services

Alcohol Problem Not Addressed

42 CFR § 438.15 (g)(1) requires a skilled nursing facility to provide medically-related social services to attain or maintain the highest practicable physical, mental and psychological well-being of each resident.

The facility was found not to have conducted adequate interventions to stop a resident from leaving the facility on weekends to abuse alcohol and return to the facility intoxicated, creating an unacceptable risk of harm to him and other residents.

His physician recommended he not be allowed to leave, or that an alternative placement be found for him that could meet his needs, but the social work charting was inattentive to his alcohol problem

Restraints in Use

Injury Permitted

42 CFR § 438.25 says in general terms that the facility must provide necessary care and services to attain or maintain the highest practicable level physical, mental and psychological well-being in accordance with the resident's comprehensive assessment and plan of care.

A resident in a geri chair was allowed to slide so far forward that her pelvic restraint wedged into her body folds. The inspectors believed it had to have been happening repeatedly to cause the injuries to her perineum and upper thighs they observed.

The facility was faulted for not getting a specially-fitted wheelchair or at least ordering a supply of the pommel cushions which could have been used to keep her positioned properly.

The facility's argument was that she was small of stature, demented, agitated and would not sit still. In the court's judgment that did not excuse what happened, but instead made it all the more necessary for staff to be attentive to her needs.

Pressure Sores

Positioning, Incontinence Care Faulted

42 CFR § 438.25 (c) says that a facility must ensure that -

(1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable, and

(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

The inspectors found a resident with an advanced pressure sore on her coccyx. The resident was wearing a foul-smelling, urine-saturated incontinence brief with "5:25 a.m." and the initials of a previous-shift staff member jotted on it. That is, she had been ignored for a 3 1/2 hour period.

The court also said there was no pressure-relief device on the chair in her room.

The facility argued that this resident was at high risk for pressure sores. Just saying that, in and of itself, does not show that the resident was receiving necessary care and services to promote healing and prevent new pressure sores, the court pointed out.

Incontinence Care

Unsanitary Cleansing Technique

42 CFR § 438.25 (d)(2) says that a resident who is incontinent of bladder must receive appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

(Continued on next page.)

Skilled Nursing, Medicare Standards (Continued.)

(Continued from previous page.)

An inspector observed an aide wiping stool from a resident's perineal area forward toward the area of her urinary tract without turning the cloth to a clean side or getting another clean cloth.

The resident did not then have or later develop a urinary tract infection. Only on one occasion did the inspector see her receive incontinence care.

However, actual harm to a resident is not necessary for a violation of Medicare standards to occur. The court sided with the inspectors on this issue. All that is necessary for a violation is inappropriate care that creates a risk of more-than-minimal harm to a resident.

Range of Motion
No Knee Splints

42 CFR § 438.25 (e)(1) says that a facility must ensure that a resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

One resident, who entered with no range-of-motion deficits in his lower extremities, developed limitations in both knees despite orders from his physician for knee splints on an alternating four-hours-on, four-hours-off cycle. The physician's orders were implemented nine days late, after the inspection.

The facility argued that he was bedridden and was not going anywhere. Furthermore, he was easily agitated and often refused to take his pills. The court pointed out, however, that Medicare standards contain no "difficult to work with" exemption. A physician's orders must be followed or at least there must be competent documentation why not, the court said.

Janitor's Closet Not Locked
Created Accident Hazard

42 CFR § 438.25 (h)(1) requires a facility to ensure that the residents' environment remains as free of accident hazards as is possible.

The court accepted the state inspectors' observation that the janitor's closet was not locked and validated their judgment that an unlocked janitor's closet poses an unacceptable risk of harm due to the presence of dangerous substances that dementia patients could get into.

The court rejected the facility's argument that it could not be penalized with no actual harm happening to a resident. The court reiterated again that the potential for more than minimal harm to a resident is all that is required to impose a civil monetary penalty on a nursing facility.

Two Persons To Assist In Transfer
Only One Aide Involved – Fall

42 CFR § 438.25 (h)(2) requires a facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents.

One resident's nursing and occupational-therapy assessments pointed to the need and her care plan stated that she was to have two staff members for bed mobility, toileting, transfers and bathing.

In reading her chart the state inspectors found a past incident where she slid out of her geri chair, fell to the floor and injured her forehead and nose, while in the bathroom with only one aide.

When the surveyors questioned the aide about the incident the aide said she had put a gait belt on the resident's waist, then stood in front of her and tried to raise her to a standing position.

If another staff member had been present, per the resident's care plan, the other person could have grasped the gait belt correctly from behind the patient and prevented her fall, the court concluded.

The court was not swayed by an occupational-therapy assessment two weeks later to the effect the resident was mentally alert and physically strong enough for one-person assists in transfer. It was not relevant to the time frame in question; at that time she was still a two-person-assist patient. **Harmony Court v. Leavitt, 2006 WL 2188705 (6th Cir., August 1, 2006).**

Postpartum Bleeding: Jury Rules Nurses Not At Fault.

Six hours after an induced delivery the patient had to have a dilation and curettage under saddle-block anesthesia because she had been expelling large blood clots. Fifteen minutes after the D & C she coded and died. The cause of death could not be established in the autopsy.

The family's lawsuit, among other things, alleged faulty monitoring by the postpartum nurses before the D & C.

The nurses reported to her obstetrician that she had stable vital signs but was expelling large blood clots, some estimated at 500 cc, and had lost a lot of blood while voiding urine. The nurses did not flush the toilet, so that the physician could see what was there when he came to see the patient. The nurses also re-started a specified dose of pitocin and performed uterine fundal massage as ordered.

The Superior Court of New Jersey, Appellate Division, approved the jury's verdict exonerating the physicians, nurses and hospital.

The jury rejected the family's nursing expert's opinion that the nurses should have counted and calculated a total net fluid weight for all the pads she had used. **Hein v. Community Medical Center, 2006 WL 2265100 (N.J. App., August 9, 2006).**

Nursing Home Arbitration Thrown Out.

The District Court of Appeal of Florida ruled that an alternative-dispute-resolution clause in nursing-home admission papers is invalid if it tries to limit the resident's rights set out by state nursing-home statutes. The resident can file suit in court to enforce his or her rights. **SA-PG-Ocala, LLC v. Stokes, __ So. 2d __, 2006 WL 2347369 (Fla. App., August 11, 2006).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Freedom Of Speech: Aide Sues For Retaliation, Nursing Home Conditions Are A Matter Of Public Concern.

A nursing-home staff member's position as restorative aide was eliminated.

She responded by trying to circulate a petition among professional staff and residents at the nursing home asking for a meeting with management.

Management responded by suspending her and then terminating her. She sued for wrongful termination, alleging that her Constitutional right to Freedom of Speech had been violated.

The Superior Court of Connecticut refused to dismiss the case and ruled that it should be heard and decided by a civil jury.

Speaking Out On Issues of Public Concern Cannot Be Object of Employer Retaliation

The court set the guidelines for how the jury was going to consider the evidence.

Was this essentially a private dispute between an employer and an employee over the employee's job title, description, duties, pay, benefits, schedule, etc.? If so, it is not a matter of public concern. The First Amendment to the US Constitution does not pertain to freedom to express one's views on purely private issues.

Or did it actually involve the issue of the quality of care at the nursing home?

The court did rule that as a general rule the quality of care that residents receive in nursing homes, or in a particular nursing home, is a matter of public concern. An employee cannot be subjected to reprisals for speaking out, or trying to speak out, on a matter of public concern. If an employee is subjected to such unlawful retaliation, the employee would have the right to file a civil lawsuit for wrongful termination.

The task for the jury will be to sort out just what was going on. Was it just an argument between the aide and her former boss or did it really have something to do with the larger issue of the quality of care for the residents? **Young v. Trinity Hill Care Center, 2006 WL 1461166 (Conn. Super., May 11, 2006).**

Psych Take-Down, Positional Asphyxia: Court Upholds Family's Wrongful Death Lawsuit.

The patient admitted himself voluntarily to a public psychiatric hospital. It was the first time he had ever been in any psychiatric facility.

The admission form, however, stipulated that he could be held involuntarily up to three days if he tried to sign out against medical advice.

During his first night, before a patient room had been assigned to him, while he was being kept in a "quiet room," he became increasingly agitated. By 9:30 a.m. he was wandering in and out of patient rooms and banging his head on the doors. The on-call physician was notified and he phoned in an order for IM Ativan. The alarm was sounded to summon staff to restrain him so that the nurse could give him the shot in his buttocks.

Use of excessive force in restraining a psychiatric patient can lead to a lawsuit for violation of state statutes that outlaw patient abuse and neglect.

The family would also have the right to sue for civil assault and battery. The analogy to a police officer is correct. Even if making a lawful arrest, use of force beyond what is necessary is illegal.

UNITED STATES DISTRICT COURT
MICHIGAN
August 10, 2006

Eight staff members kept holding him down on the floor after he got his medication. One person knelt on his neck and another stood on his head. No one checked his breathing.

He was let go of when he quieted down apparently from the medication taking effect. In fact, he had been asphyxiated and had died.

The US District Court for the Western District of Michigan would not say his Constitutional rights were violated.

However, the family could still sue for wrongful death under state statutes which outlaw abuse and neglect of patients by healthcare caregivers and could sue for common-law civil assault and battery for use of excessive force. **Lanman v. Hinson, 2006 WL 2331185 (W. D. Mich., August 10, 2006).**