LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

September 2007 Volume 15 Number 9

Nurse As Patient's Advocate: Cardiac Care Nurse To Share Liability With The Physician.

A fifty-three year-old man who came in with chest pains was transferred to the cardiac service for a diagnostic cardiac catheterization after the E.R. doctor determined the man had had a mild heart attack.

During the diagnostic procedure the cardiologist found significant arterial blockage and decided to do a stent angioplasty two days later.

In preparation for the angioplasty the cardiologist started the patient on aspirin and Plavix to inhibit platelet aggregation. The anticoagulant heparin was started at 1,000 units per hour.

A partial thromboplastin time (PTT) was done six hours into the heparin therapy. It was slightly longer than normal so the heparin was reduced to 900 units per hour.

Eleven hours later the patient developed a severe headache, profuse sweating, nausea, vomiting and markedly increased blood pressure, signs and symptoms of the onset of what proved to be a fatal intracranial bleed.

The Superior Court, Essex County, New Jersey jury reached a verdict of more than $1,000,000 for his probate estate for wrongful death from malpractice.

The patient's nurse was ruled 5% responsible for payment of the verdict along with her employer the hospital.

A nurse has a fundamental legal duty to act as advocate for the nurse's patient.

A nurse with specialized clinical training and experience is expected to understand the medical issues and is held to a high legal standard of care.

A nurse must seek physician's orders to correct an apparent oversight.

SUPERIOR COURT, ESSEX COUNTY
NEW JERSEY
July 3, 2007

Cardiac-Care Nurse Failed to Advocate for the Patient

At 900 units per hour the patient was still on a significant dose of anticoagulant. The one and only PTT that was actually done, six hours after the infusion began, was slightly longer than normal.

The experts testified that an experienced cardiac-care nurse should recognize the high risk and the grave danger of a cerebrovascular event with the heparin still running and should know that a repeat PTT, no later than six hours after an elevated PTT, is the standard of care.

The nurse testified in her defense that a repeat PTT could not be done without a physician's order.

The jury ruled, in effect, that the nurse should have acted as advocate for her patient by seeking a physician's order for a repeat PTT no later than six hours after the first PTT.

The nurse nevertheless did see the import of the headache, sweating, nausea vomiting and increased blood pressure and did notify the cardiologist promptly.

The cardiologist waited to come to see the patient, minimized the seriousness and waited several more hours to get a neurology consult. The patient actually died on his way to get a CT. **Oakley v. Bhalodia, 2007 WL 2246911 (Sup. Ct., Essex Co., New Jersey, July 3, 2007).**

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Status Asthmaticus: Nurse To Share Blame For Ten Year-Old Child's Death In The E.R.

A jury in the Supreme Court, Kings County, New York awarded $3,500,000 to the parents of a ten year-old child who died in a hospital emergency room in the throes of an asthmatic attack.

The scenario portrayed at trial was a complex series of alleged errors and omissions by the emergency-room medical and nursing staff.

The jury apportioned 10% of the verdict against the emergency room nurse.

Bucking the Respirator
Patient Restrained

The emergency room nurse testified at trial she believed that a ten-year old child bucking her respirator during an acute asthma attack should be handled as a "combative" patient, that is, she believed the emergency room staff were justified in tying her down to her bed.

Endotracheal Tube Removed
Out for Fifteen Minutes

The nurse noticed that the endotracheal tube seemed to have been inserted too far. Instead of just pulling the tube back three to five centimeters and calling the anesthesia service for someone with expertise, the nurse reported it to the emergency room physician, who pulled the tube all the way out.

It stayed out fifteen minutes, with the patient unable to breathe, waiting for anesthesia to come and re-intubate the patient.

Epinephrine Overdose

During the code blue the nurse apparently administered one of a total of eight ten milligram doses of epinephrine that were given the patient. The experts testified that .35 milligrams is the maximum for any single pediatric dose of epinephrine.

The verdict was meant to compensate the parents for the loss of their child and to compensate the child's probate estate for the conscious pain and suffering the child herself experienced during her final ordeal. **Rivera v. City of New York et al., 2007 WL 2247127 (Sup. Ct., Kings Co., New York, June 26, 2007).**

When 911 emergency paramedics brought the girl to the emergency room, hospital personnel told her mother they would not treat her daughter until she was registered.

The doctors started by intubating the patient right away. She was intubated without first trying to treat her with respiratory medications like albuterol and/or IV corticosteroids.

The patient was intubated without administration of sedatives, muscle relaxants or a paralytic agent.

The patient began bucking the respirator. Medications were administered to stop the bucking, but only after she had been intubated.

The respirator was set at 40 breaths per minute, rather than 8 to 10. Positive end expiratory pressure (PEEP) was set at 5, which the expert witnesses testified was inappropriate during an acute asthma attack.

8 x 10 mg epinephrine doses were given over 85 minutes, which the experts testified is many times the maximum single and cumulative pediatric dosages.

SUPREME COURT, KINGS COUNTY
NEW YORK
June 26, 2007

Extravasation: Hospital Pays Settlement For Poor Nursing Documentation.

A one month-old premature infant was still in the hospital's neonatal intensive care unit. She had fluid infusing through an IV site on her right calf.

The night nurse came on duty at midnight. Her first progress note mentioned that all was well with the IV. The nurse wrote another progress note at 1:00 a.m. which mentioned nothing about the IV site.

At 2:30 a.m. the nurse found the IV site swollen and discolored from infiltration of fluid into the surrounding tissue. The nurse stopped the IV, but not before a permanent residual cosmetic deformity was created on the baby's right lower leg.

There was a 2 1/2 hour gap in the nursing progress notes while the patient's IV fluid extravasated.

The site should have been checked, perhaps actually was checked every 30 minutes, but the proof it was checked was spotty at best.

NEW YORK COURT OF CLAIMS
May 9, 2007

The hospital's lawyers offered a $650,000 settlement right before the case was to go to trial in the New York Court of Claims, and the parents accepted.

The parents' lawyers were prepared to point a finger of blame at the fact there were no nursing progress notes to prove the IV site was checked q 30 minutes per hospital policy, or at least every hour as the experts were going to testify is the national standard of care, notwithstanding the fact the nurse's initials were marked for the IV every 30 minutes on the ICU nursing flow sheet. **Sam v. State of New York, 2007 WL 2175371 (N.Y. Ct. Claims, May 9, 2007).**

Developmental Disability: Hospital Liable For Fall From Window.

A thirty-seven year-old developmentally disabled hospital patient pulled out his urinary catheter with the bulb still inflated, causing severe bleeding, then got out of his bed and began pounding on the window in his room.

Soon he managed to open the window, climbed out, fell six stories and was badly injured. The jury in the Superior Court, San Diego County, California awarded him $1,074,102 from the hospital.

The evidence at trial was that the nursing staff ignored his pounding on the window, assuming he would not or could not open the window, having earlier ignored his treating physician's suggestions for a sitter and/or a bed alarm.

The hospital's facilities management was faulted for the fact that patient windows could easily be opened from the inside, with no safeguards in place to keep patients from going out. **Sanchez v. Scripps Health, 2007 WL 2197686 (Sup. Ct. San Diego Co., California, June 20, 2007).**

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E. Kenneth Snyder, BSN, RN, JD
Editor/Publisher
PO Box 4592
Seattle, WA 98194–0592
Phone (206) 440-5860
Fax (206) 440-5862
kensnyder@nursinglaw.com
www.nursinglaw.com

EAP: Court Discusses The Legal Standard Of Care For Nurses.

An employee assistance program (EAP) provides counseling on a voluntary basis and acts as mental-health triage for assessment and referral to specialized providers of care.

In this case the employee assistance program consisted of three professionals, a certified counselor, a physician board-certified in internal medicine and a registered nurse.

Each member of the team has specialized skills. Each member of the team is held only to the standard of care for professionals in his or her own profession.

None of the EAP team members was a board-certified psychiatrist. None of them were expected to provide psychiatric care.

A nurse is not expected to treat the complex issues associated with a client's major depression and cannot be held liable for his suicide.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
August 1, 2007

After her husband killed himself the widow filed suit against his then-employer alleging that the company's employee assistance program was negligent for failing to diagnose and treat his depression, thus causing his suicide.

The Superior Court of New Jersey, Appellate Division, dismissed the case against the company, finding no fault with the mental health counselor, internist and registered nurse who made up the employee-assistance program team. The patient's outside psychiatrist was not dismissed.

Nurse's Role in an Employee Assistance Program

A nurse's role in an employee assistance program is to work with employees who seek help for their personal problems.

The nurse's jobs are to assess clients' needs, strengths and weaknesses, refer clients to resources which can provide appropriate treatment and then to motivate and support clients as they receive help from outside sources to resolve their issues.

An employee-assistance nurse can only deal with employees who voluntarily come forward seeking help.

The nurse is not expected to monitor the workforce to detect which employees seem to have problems and to solicit such employees to enter some sort of treatment.

Signs that an employee is in danger from a mental-health crisis, which may be apparent to the employee's co-workers but which are not communicated by the employee to the nurse, are not the nurse's legal responsibility to deal with. **Karak v. E.I. Dupont, 2007 WL 2188522 (N.J. App., August 1, 2007).**

Chemical Dependency: Nurse's Intoxication Can Lead To Legal Liability.

The parents sued the hospital alleging that negligence by the hospital's medical and nursing labor and delivery team caused their infant's cerebral palsy.

The focus at the trial was the fetal monitor strips. The strips revealed that the fetal heart rate dropped below seventy for almost twelve minutes.

The jury nevertheless ruled the doctors and nurses were not negligent.

Almost two years later the family's lawyer somehow obtained a copy of the labor and delivery nurse's personnel file. Her file revealed she had an ongoing chemical dependency problem during the general time frame of the events in the labor and delivery department that had sparked the parent's lawsuit.

The family's lawyer tried to re-open the lawsuit with a new theory of liability. He argued that the hospital was negligent for hiring and/or retaining a nurse suffering from chemical dependency. Her impairment caused her to neglect her duty to watch the monitor strip. That explained why the labor and delivery team failed to pick up on the low fetal heart rate. That was substandard care and caused the baby's cerebral palsy.

Chemical Dependency Itself Not a Basis for Legal Liability

The Minnesota Court of Appeals ruled that a nurse's ongoing chemical dependency problem, in and of itself, is not a valid basis to impose legal liability on a hospital for an adverse event involving the nurse.

On the other hand, proof that the nurse was intoxicated on duty while participating in the adverse event that sparked the lawsuit could be grounds for legal liability, the court said. No such proof, however, actually existed in this case. **Kelly v. Guttormsson, 2007 WL 2245085 (Minn. App., August 7, 2007).**

Pitocin, Vaginal Delivery Post-Cesarean: Nurse Must Watch For Uterine Hyper-Stimulation.

The Court of Appeals of Texas saw the trial as a classic battle of the experts. One side claimed that Pitocin may only be used with extreme caution, if at all, to induce vaginal delivery after a prior cesarean. The other side claimed there was no scientific data linking Pitocin to increased risk of uterine rupture.

It was apparent that the hospital's labor and delivery nursing staff was largely unfamiliar with the concept that Pitocin can be associated with a risk of uterine hyper-stimulation, uterine rupture and placental abruption.

COURT OF APPEALS OF TEXAS
August 16, 2007

The court upheld the jury's verdict for the mother and child.

Uterine Rupture

Based on the package-insert warnings the court said when Pitocin is used post-cesarean the labor and delivery nurses must watch the monitors carefully for signs of uterine hyper-stimulation.

Delay in Cesarean

When vaginal delivery has to be abandoned in favor of a cesarean the nurses have responsibilities in getting it done very quickly. A nursing supervisor must be notified if a physician is not immediately available to start the procedure. The nurses must move the patient to the operating room and prep her with the utmost speed. **Christus Spohn v. De La Fuente, 2007 WL 2323989 (Tex. App., August 16, 2007).**

Pitocin With Cytotec: Jury Rules Nurse Must Watch For Uterine Hyper-Stimulation.

A jury in the Superior Court, Essex County, New Jersey, returned a verdict of $11, 697, 273.99 for an infant and her family after the infant was born with severe hypoxic brain damage.

The jury ruled the ob/gyn physician 67.4 % and the labor and delivery nurse 32.6% liable for payment of the damages.

The physician used a dose of 50 micrograms of Cytotec intravaginally to induce labor. Not quite four hours later the labor and delivery nurse started Pitocin and gradually increased the infusion rate.

Three hours after she started the Pitocin the nurse discontinued it because of ominous signs she saw on the monitor. She began trying to locate the physician, who apparently was sleeping in the physician's lounge. The baby was delivered by c-section two hours and ten minutes after the Pitocin was stopped.

The physician was faulted for ordering Pitocin less that four hours after "off-label" use of Cytotec to induce labor. It is a stomach-ulcer medication with a known side-effect of stimulating uterine contractions.

The drug manufacturer reportedly settled with the family for $2,000,000 more out of court for failing to provide label or package-insert warnings about all the known dangers of mixing Cytotec with Pitocin.

The labor and delivery nurse was faulted for going against hospital rules by starting the Pitocin too soon, less than four hours after the Cytotec, for failing to appreciate the risk and danger to the fetus from uterine hyper-stimulation and for failing to watch the monitor closely enough.

The physician and the nurse were both faulted for inexcusable delay in starting the c-section. **Moeltner v. Rubio, 2007 WL 2246846 (Sup. Ct., Essex Co., New Jersey, March 6, 2007).**

Abuse: Aide's Firing Ruled Justifiable.

An aide was fired from her position in a nursing home for allegedly slapping the face of an elderly resident.

The Appellate Court of Illinois agreed with the state department of employment security the aide was fired for just cause.

Physical Discipline = Abuse

According to the court, any touching of a patient is considered abusive if it is not directly related to providing care.

That is, no physical contact whatsoever is permitted as a means to discipline a patient or to correct a patient's behavior.

It was not relevant whether the aide actually slapped the patient as was alleged, or merely touched her face to get her to calm down as the aide herself maintained. **Livingston v. Dept. of Employment Security, __ N.E. 2d __, 2007 WL 2163996 (Ill. App., July 27, 2007).**

Abuse: Patient Bruised Being Restrained.

The elderly dementia patient always required two nursing home staff to assist her to use the bathroom.

One particular day the patient did not want anyone helping her. As both of the aides held her under the arms and lifted her from the toilet she became agitated and started punching one of them.

The aide grabbed her by both wrists and held her. Five hours later bruises were visible on both of the patient's wrists.

Excessive Force = Abuse

The Court of Appeals of Iowa ruled the aide committed dependent adult abuse. Even when it is necessary to handle a patient bodily to provide personal care or to restrain a patient physically to insure the patient's own safety, use of excessive force is considered abusive. **Sciacca v. Dept. of Human Services, 2007 WL 2004531 (Iowa App., July 12, 2007).**

Post-Mortem Care: Hospital Did Not Inflict Emotional Distress On Family Member.

Even though the hospital's policies and procedures were not followed to the letter, the Supreme Court of Delaware refused to allow a family member to sue for infliction of emotional distress for inadvertently being allowed to glimpse the remains fresh post-autopsy.

The court did endorse in general terms the hospital's policies and procedures for handling requests by the next of kin to view the remains of a family member.

Requests to View Remains Post-Mortem

Hospital staff were to forward requests to view remains to the clinical coordinator.

If the case was not under the medical examiner's jurisdiction and the requesting party was an immediate family member the morgue was to be contacted beforehand to prepare the body for viewing.

Nurse's Role As Support Person

When the time came, a nurse was to be assigned to act as the support person to accompany the family member to the morgue. The court said that the unit secretary who accompanied the family member to the morgue in this case was not the right person for the support-person role.

The family member was to view the remains from a room adjacent to the room where the bodies were stored and worked on, separated from that room by a window with blinds kept closed and opened only at the appropriate moment.

In this case the family member decided at the last moment she did not want to view the remains. She could still see through a gap in the viewing-window blinds.

She saw the deceased on the autopsy table not yet prepared for viewing by a family member post-autopsy. **Goode v. Bayhealth Medical Center, 2007 WL 2050761 (Del., July 18, 2007).**

Identity Theft: Hospital Aide Convicted.

A nurses aide used her employment position to obtain confidential information from hospital patients' charts and co-workers' pay stubs.

She sold the information to an accomplice who fraudulently applied for credit cards and used the credit cards to purchase almost $250,000 in merchandise.

The US Court of Appeals for the Fourth Circuit upheld the aide's conviction and two-year prison sentence for violation of the US Federal identity-theft statute.

The court's opinion in the criminal case did not elaborate upon the hospital's potential civil liability. **US v. Occident, 2007 WL 1988454 (4th Cir., July 6, 2007).**

Whistleblower: Nurse May Have Right To Sue.

The Court of Appeals of Kentucky did not resolve the case one way or the other, except to say that the lower court should not have ruled summarily in favor of an RN's former employer, a long-term care facility, in the RN's employment dispute, without giving the RN her day in court to present her evidence and her arguments to the jury as to the real reason she was fired.

Employer Retaliation

A healthcare employer cannot fire a nurse for doing his or her legal, ethical and moral duty to advocate for a patient by complaining, as in this case, that the physician should have been called for a nursing-home resident who needed medical care.

Abusive, Disruptive Behavior

On the other hand, regardless of the underlying issues, an employer can expect a nurse to act professionally toward his or her co-workers by refraining from abusive, discourteous and confrontational behaviors. **Vanhook v. Britthaven, 2007 WL 2142691 (Ky. App, July 27, 2007).**

English-Only Rules: US Court Distinguishes Legitimate vs. Discriminatory Policies.

Several Spanish-speaking employees sued a hospital for national-origin discrimination under Title VII of the US Civil Rights Act.

The US Court of Appeals for the Tenth Circuit ruled that the hospital's English-only rule met currently accepted guidelines and was not discriminatory.

The court explained that English-only rules can, in some circumstances, create a hostile environment for Hispanics in their workplaces and, as a subtle form of national-origin discrimination, foster a sense of inferiority, isolation and intimidation.

However, the US courts and the US Equal Employment Opportunity Commission (EEOC) distinguish between two types of English-only rules.

Across-the-Board Policy
Discriminatory

An across-the-board English-only policy blithely and mechanically enforced by the employer at all times, in all places and in every circumstance in the work environment is considered discriminatory.

Tailored Policy
Founded in Business Necessity
Not Discriminatory

Contrast that with an English-only policy which is tailored only to certain times and places to ensure clear communication between employees and with patients and members of the public, a legitimate consideration for a healthcare facility. That is not considered discriminatory.

Spanish-speaking housekeeping staff in the surgical department were required to communicate with the nurses and with each other in English only in the surgical department and only about their job tasks.

English Proficiency at Time of Hiring

The court also said, assuming the English-only policy at the facility is not discriminatory, employees who will be subject to the policy can be screened for English proficiency at the time of hiring. **Montes v. Vail Clinic, Inc., __ F. 3d __, 2007 WL 2309766 (10th Cir., August 14, 2007).**

Clear and precise communication is essential between the operating-room nursing staff, most of whom at this hospital do not speak Spanish, and the members of the housekeeping staff assigned to the operating room who speak Spanish as their first language.

Maintaining sanitary conditions in the operating room is of paramount importance to the hospital's operations and to the health and safety of patients. Quick and efficient turn-around is a legitimate business consideration for a surgical facility.

The hospital's English-only rule in the surgical department required communication in English with English-speaking staff and among Spanish-speaking staff only in the surgical department and only for job-related discussions.

Spanish-speaking employees were allowed to speak Spanish with each other during breaks and while conversing on the job about non-job-related topics.

A blanket rule against Spanish at all times and places is discriminatory.

UNITED STATES COURT OF APPEALS
TENTH CIRCUIT
August 14, 2007

Full Code Patient: Failure To Respond Is Grounds For Termination.

The US District Court for the Southern District of Mississippi ruled that a male minority LPN had no grounds to file suit for discrimination against his former employer, a long-term care facility.

The facility required all personnel to respond and assist in CPR when a code was called for any full-code patient in the facility. The LPN just sat in the break room chatting on his cell phone and finished his sandwich, the court said, then later tried to falsify the patient's chart to show he had been on the code. **Davis v. AltaCare Corp., 2007 WL 2026438 (S.D. Miss., July 9, 2007).**

No One-To-One Monitoring: Hospital Can Suspend Nurse.

The US District Court for the District of Columbia ruled that a sixty-two year-old minority nurse had no grounds to claim that discrimination was her employer's motivation for suspending her for nine days.

As charge nurse on a mental-health ward she told a staff nurse to monitor a certain patient one-to-one who was being disruptive and verbalizing violent threats.

The charge nurse took over the patient when the staff nurse went to lunch.

The charge nurse admitted she just tried to keep an eye on the patient but did not actually monitor the patient one-to-one as she had directed the other nurse.

The patient barged into the nurses' break room, took a knife and threatened to kill herself. While being disarmed another knife was found on her person. **Banks v. District of Columbia, __ F. Supp. 2d __, 2007 WL 2188652 (D.D.C., August 1, 2007).**

Back Injury: Court Rules Nurse Does Not Have A Disability.

While she was recovering from back surgery to correct the effects of three on-the-job injuries the hospital provided an RN with a temporary light-duty accommodation. Unlike other nurses, she did not have to lift, pull or turn patients, push wheelchairs or do any physical tasks in excess of the ten-pound lifting restriction her physician imposed.

Eventually human resources insisted the temporary accommodation had to end and the nurse had to settle into a permanent position. The nurse declined a case manager position which happened to be open, voicing a preference to remain in direct care with a no-lifting accommodation.

Her preference was not honored. She sued for disability discrimination.

The US Supreme Court and the US Equal Employment Opportunity Commission (EEOC) have explicitly said that a nurse's physical inability to work any longer in the nurse's position of choice, direct patient care, is not what the law contemplates as a disability.

UNITED STATES COURT OF APPEALS
SEVENTH CIRCUIT
August 16, 2007

The US Court of Appeals for the Seventh Circuit reiterated what the courts and the EEOC have been saying all along.

The Americans With Disabilities Act does not confer any rights on a direct-care nurse whose lifting capacity due to a back injury does not meet the employer's legitimate requirements. **Squibb v. Memorial Medical Center, __ F. 3d __, 2007 WL 2325173 (7th Cir., August 16, 2007).**

Perioperative Nursing: Court Discusses The Standard Of Care.

The circulating nurse is the surgical patient's advocate. The circulating nurse is responsible for the patient's safety while the patient is under his or her care.

The circulating nurse should actively participate in safely positioning and padding the patient, continuously monitor body alignment and tissue integrity based on sound physiological principles and communicate specific needs to the rest of the surgical team.

The fact the anesthesiologist or anesthetist documents "all pressure points checked and padded" does not relieve the circulating nurse from his or own responsibility for accurate and thorough documentation. The type of padding used and the specific sites where it was placed should be documented in the intra-operative nursing notes.

Incomplete intra-operative nursing documentation is a violation of the standards published by the AORN and the ANA.

Those organizations' publications are widely recognized by the courts as authoritative references on the legal standard of care in various nursing settings.

COURT OF APPEALS OF TEXAS
August 3, 2007

The patient sued the hospital for a radial nerve palsy that was allegedly caused by the registered nurse anesthetist's negligence in positioning and padding her arm for gynecological surgery.

The Court of Appeals of Texas dismissed the nurse anesthetist from the case. The court ruled that the nursing experts' reports that were filed in the case, while right on the mark as statements of the standard of care for circulating nurses, were not directly applicable to the nurse anesthetist's role in the operating room.

Importance of Nursing Documentation

An overarching principle reiterated by the court was that nurses have the responsibility not only to provide safe and effective care but also to document concrete facts showing how safe and effective care was provided.

Lack of complete nursing documentation can lead a judge or jury directly to the conclusion that care was not provided or that the care provided was not safe and effective, that is, the nurse was negligent.

IV, Arm Board, Padding, Positioning

The circulating nurse has the responsibility to inspect the patient's IV site visually and, before the patient is placed under anesthesia, to ask the patient if it is causing any discomfort. If the patient reports a problem with the IV the circulating nurse must fully document to whom it was communicated and what was done about it.

When the arm is positioned on the arm board, after the patient is under anesthesia, the circulating nurse must check that the tape is not wrapped around the wrist, which can damage the radial nerve, and, if so, must insist the tape be removed and placed around the middle of the forearm.

The circulating nurse must continuously check the hand and wrist for swelling, a telltale sign the tape is too tight.

The circulating nurse should watch whether the patient is moved during the procedure. The positioning and padding of the entire body at the onset might not be appropriate after the patient is moved. **Ledesma v. Shashoua, 2007 WL 2214650 (Tex. App., August 3, 2007).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Bed Alarm: Nursing Facility Settles With Widow For Fall.

The patient was admitted to a nursing home in his late sixties suffering from Alzheimer's disease.

He had a history of falls. His wife insisted that the nursing home obtain and start using a device designed to be kept on his person, whether he was in bed, in a regular chair or in a wheelchair, which would trigger an alarm when he started to move to any significant degree.

He was put to bed one night without his alarm. He was found on the floor with a broken hip. Due to his advanced dementia, he just lay there on the floor in pain for some time and did not cry out for help. The hip fracture started a downward spiral in his health which ended in his death from pneumonia.

His widow's lawsuit in the Circuit Court, Waupaca County, Wisconsin was settled for $87,000 before trial. **Labarge v. Wisconsin Veterans' Home, 2007 WL 2216534 (Cir. Ct., Waupaca Co., Wisconsin, March 17, 2007).**

Elopement Alarm: $2,200,000 Verdict Against Nursing Facility.

The elderly Alzheimer's patient was fitted with an ankle bracelet meant to trigger an alarm to alert staff if he tried to leave the facility.

The bracelet system was not working. He eloped. While wandering the neighborhood he fell and cut his leg. In his widow's lawsuit it was alleged the facility neglected to have the laceration treated, the wound became infected and the patient actually died from the infection.

The jury in the Circuit Court, Houston County, Alabama awarded $2,200,000. The jury seems to have been particularly incensed by the inexcusable failure to provide medical care post-elopement and by evidence that the facility was only licensed as an assisted-living facility and had no business admitting a heavy-care Alzheimer's patient in the first place. **Miller v. Terrace at Grove Park, 2007 WL 2216409 (Cir. Ct. Houston Co., Alabama, February 9, 2007).**

Patient's Latex Allergy: Nursing Facility Cited For Physical Abuse, Civil Monetary Penalty Upheld.

A nursing assistant wore latex gloves while caring for a nursing home resident with a known latex allergy documented in his chart, causing the resident to suffer an allergic reaction which necessitated hospitalization.

The facility was cited for a series of four staff errors:

1. The nursing assistant was unfamiliar with the resident and his allergy;

2. Warning signs about the latex allergy were missing from the resident's room;

3. The nursing assistant did not receive a verbal warning in report at the beginning of her shift about the allergy; and

4. The nursing assistant herself failed to consult the resident's chart until the end of her shift.

Federal regulations require long-term care facilities to develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents (42 CFR 483.13 (c)).

Inspectors saw a pattern of neglect in implementing basic safeguards for residents who had life-threatening allergies, that is, a situation of immediate jeopardy did exist.

UNITED STATES COURT OF APPEALS
FOURTH CIRCUIT
July 20, 2007

Court Sees System-Wide Weaknesses in Facility's Quality of Care

The US Court of Appeals for the Fourth Circuit turned down the facility's appeal. The court agreed with North Carolina state inspectors this was not an isolated error by a single caregiver, but instead showed a wider pattern of failure to implement protective measures for the safety of dependent patients. Thus this particular violation of Federal regulations did pose immediate jeopardy to the health and safety of the other residents.

The measuring rod for penalties for non-compliance with CMS regulations is not the actual harm to a particular resident but the potential for harm to other residents that the incident reveals. **Liberty Commons Nursing and Rehab Center v. Leavitt, 2007 WL 2088703 (4th Cir., July 20, 2007).**