LEGAL EAGLE EYE NEWSLETTER

September 2010 For the Nursing Profession Volume 18 Number 9

Patient's Fall: Nurse's Retraining After An Accident Is Not Proof Of Nursing Negligence.

A ninety-one year-old nursing home patient fell and broke her hip. The injury required surgery followed by an extended hospital stay.

The patient filed a personal injury lawsuit against the nursing home. The lawsuit was continued after her passing on behalf of the family by the administrator of her probate estate.

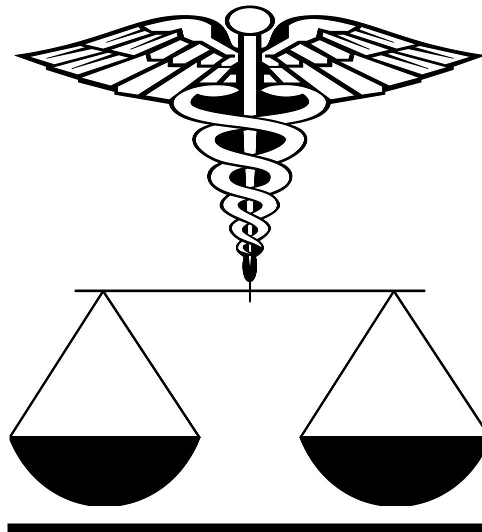
Deposition of the Patient's Nurse Ruled Not Appropriate

The lawyers representing the estate sought a court order requiring the nurse who was assigned to care for the patient when she fell to answer questions under oath in a deposition.

The lawyers' plan for the deposition was to question the nurse in detail specifically about the retraining she received after the incident from her supervisors how her actions at the time could have more effectively met her patient's safety needs.

The issues touched upon in the retraining the nurse received after the incident, the estate's lawyers believed, would identify deficits in the nurse's competency at the time of the incident which would tend to bolster the estate's claim of negligence.

The judge in the Civil Court, City of New York, New York ruled, however, that the lawyers' plan for the nurse's deposition was not appropriate.



The law seeks to encourage rather than discourage improvements based on adverse experiences.

After an accident an institution may find it in its clients' best interests to take precautionary measures to avoid similar incidents.

Subsequent remedial measures are not admissible in court to prove negligence.

CIVIL COURT
CITY OF NEW YORK, NEW YORK
August 10, 2010

A long-standing legal rule of evidence holds that so-called subsequent remedial measures taken after the fact are not admissible to prove negligence before the fact.

The US Supreme Court has ruled that precautions taken against future harm are not to be implied as an admission of guilt or liability.

One of the rationales behind this legal rule of evidence is not to penalize but instead to encourage individuals and organizations to look back candidly at injury-producing events and to implement safeguards to prevent the same or similar events from happening again in the future.

Such precautions taken afterward are not legitimate proof of negligence at the time of the event.

The caregiver in question may have exercised all the due care that the law requires, but in the light of new experience after an unexpected accident, and as a measure of caution, may adopt additional safeguards, the Court said.

It is not necessarily true that nursing skills that a supervisor might want to review afterward with a nurse were not possessed or used by the nurse at the critical moment in question. **Alfieri v. Carmelite Nursing Home, Inc., __ N.Y.S.2d __, 2010 WL 3155936 (N.Y. City Civ. Ct., August 10, 2010).**

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EMTALA: Hospital Discharged Mother With Non-Viable Fetus, Nurse Accepted As Expert.

A woman came to the hospital's E.R. at 4:30 a.m. with abdominal cramping.

She said she was sixteen weeks pregnant and that she had been advised by her ob/gyn to go to the hospital if she had any problems, given that her pregnancy was high-risk due to a history of cervical cancer, a miscarriage, a previous c-section and pregnancy-induced hypertension.

After being seen by the triage nurse and the E.R. physician she had an ultrasound which revealed a non-viable fetus with no detectable heartbeat.

When he got the ultrasound result the E.R. doctor called in an ob/gyn who did another ultrasound which confirmed the earlier findings. Because she was not having contractions and her cervix was not ready for delivery, she was discharged home against her wishes with instructions to call her ob/gyn if she had further problems. She went home and delivered her dead fetus at about 9:00 p.m. that evening.

Court Sees EMTALA Violation Nurse Accepted As Expert Witness

The United States District Court for the District of Maine ruled that the US Emergency Medical Treatment and Active Labor Act (EMTALA) is not inapplicable merely because fetal demise has been confirmed and the mother is not, therefore, in active labor.

The question is whether the patient has an emergency medical condition which places her in medically unstable condition which poses a threat to her health or safety if she is discharged without necessary stabilizing treatment.

In this case the patient had a medical condition which required stabilization before her discharge, that is, delivery of her fetus before being allowed to leave the hospital, the Court said.

To prove that point the Court accepted an experienced labor and delivery nurse's testimony as an expert witness on the possible complications this patient was still facing when she was discharged. **Morin v. Eastern Maine Med. Ctr., __ F. Supp. 2d __, 2010 WL 3000286 (D. Me., July 28, 2010).**

Because the witness is a nurse does not mean she is not an expert. The test is whether she has scientific, technical or other specialized knowledge that will assist the judge or jury to understand the evidence or to make a decision about the facts presented in the case.

After thirty-five years as an experienced labor and delivery nurse, the witness presumably knows a labor contraction when she sees it and can testify on the basis of review of the patient's medical records whether or not she was having contractions.

She is also qualified as a nursing expert to testify about the potential complications a woman in this patient's condition would have faced.

However, a nurse is not a medical expert.

A nurse's expert testimony must be limited to a nurse's view of the signs, symptoms and processes that define the patient's health needs or reaction to actual or potential health problems, particularly those she faced after discharge from the hospital.

UNITED STATES DISTRICT COURT
MAINE
July 28, 2010

EMTALA: Patient Was Screened, Left AMA, No Violation Found.

The police took the patient into custody and called paramedics. The patient was belligerent, uncooperative and possibly intoxicated.

The police had the paramedics transport him to the nearest hospital to be checked medically, even though the patient himself voiced no medical complaints.

At the hospital the E.R. nurses took his vitals, temp 98, respirations 20, B/P 139/94 and O_2 sat 99% and noted he was uncooperative and combative. The E.R. physician saw him, obtained the same vital signs, noted that he had been drinking and had a possible history of alcoholism but was alert, awake, ambulatory and in no acute distress. The patient stated he did not want further evaluation or treatment and left against medical advice.

There was no indication the police had completed paperwork for an involuntary mental health hold.

Hours later the patient was taken by ambulance from a restaurant to a hospital where he was diagnosed with severe anemia and treated with five pints of blood.

There is no evidence the hospital departed from the standard of care or caused the patient any harm.

CALIFORNIA COURT OF APPEAL
July 30, 2010

The California Court of Appeal ruled the evidence was completely lacking that the nursing or medical personnel in the first hospital's E.R. departed from the accepted standard of care or violated the US Emergency Medical Treatment and Active Labor Act (EMTALA), despite the fact that 20/20 hindsight revealed that the patient was likely suffering from a serious medical condition at the time.

The hospital performed an appropriate medical screening and had no authority to hold him after he decided he wanted to leave. **Donegan v. CFHS Holdings, Inc., 2010 WL 2978631 (Cal. App., July 30, 2010).**

Combative Patient: Court Reviews Standards For Physical Restraint.

A developmentally disabled youth at the state school became combative with staff members who were insisting it was time for him to go to bed. He was restrained on the floor and strapped to a restraint board. After he was strapped down a nurse found him unresponsive and started CPR. Paramedics took him to the hospital where he was pronounced dead.

The Court of Appeals of Texas pointed out that the state school's own procedures for physical restraint called for the person to be held down on the floor in a side-lying position, with at least one staff member monitoring whether or not the patient was conscious and breathing.

Instead, in this incident the patient was placed on his back on a restraint board with one or more straps across his chest and/or diaphragm, which apparently made it impossible for him to breathe.

The Court ruled the boy's mother had the right to sue, assuming she could get a physician to write a report as a medical expert expressly stating that the straps across the chest were the actual mechanism which caused his death. **Salais v. Dept. of Aging & Disability, __ S.W. 3d __, 2010 WL 3036482 (Tex. App., August 4, 2010).**

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Alzheimer's: Patient Force-Fed Medication, Court Rules Nurse Did Not Abuse Her Patient.

A caregiver's name will be placed on the list of persons disqualified from working with vulnerable persons if it is determined that the caregiver knowingly or recklessly abused a resident of a facility in which the caregiver was employed.

Abuse is defined as the infliction of physical, sexual or emotional injury or harm.

This resident had been diagnosed with Alzheimer's dementia and had a long history of noncompliance with care and outright combative behavior.

Noncompliance or combative behavior during medication administration did not necessarily mean that emotional injury or harm was being inflicted on the resident by the nurse giving her her medication.

MISSOURI COURT OF APPEALS
August 17, 2010

The usual practice was to mix the patient's medications with her applesauce. If the patient was difficult, as she often was, the care plan called for the person trying to give her her medications/ applesauce to leave her alone and return later or ask someone else to try.

One day a dietary aide and a CNA reported to the director of nursing that a nurse held the patient's head back with one hand and tried to force the applesauce into her mouth with the other. When the patient started swinging her arm at the nurse the nurse told the CNA to restrain her arm as the nurse went ahead. The resident jerked her head from side to side and tried to kick and buck out of her wheelchair.

Investigators from the department of health and senior services recommended charges of patient abuse. The Missouri Court of Appeals, however, ruled the nurse committed no abuse.

In general, patients have the right to refuse treatment and to be free from restraint and coercion. Forcing medication upon a mentally competent patient who wished to refuse would be abusive.

However, combative behavior is not uncommon with dementia patients whose reasoning has been impaired to the extent they cannot function independently and must rely on caregivers for basic needs, the Court said. There was no evidence the nurse caused any physical or emotional harm. **Stone v. Dept. of Health, __ S.W. 3d __, 2010 WL 3218912 (Mo. App., August 17, 2010).**

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Falls: Care Plan Not Updated, Jury Finds Negligence.

The fifty-one year old patient was placed in a nursing facility following a below-the-knee amputation necessitated by his diabetes.

His medical diagnoses included kidney failure and liver disease. He also had issues with balance and a short-term memory deficit which translated into problems remembering what he was told by the nurses by way of patient-safety teaching.

He spent his time mostly in his wheelchair. Sometimes he was able to ambulate with a prosthesis and a cane.

The patient fell five times before the last fall in which he broke his hip.

Each fall created an opportunity and an obligation to reevaluate his condition and reassess his needs.

SUPREME COURT
NEW YORK COUNTY, NEW YORK
June 29, 2010

The patient passed away nine months after open reduction and internal fixation surgery to repair his four-part intertrochanteric hip fracture from the last fall.

The family's nursing expert testified that each of his prior falls required more than a progress note in the chart documenting the bare fact that he had fallen.

His balance problems and short-term memory deficits should have been reevaluated and attention given to new safety equipment like wheelchair tipping guards, bed brakes and sitting pads.

Merely reminding him to ring his call bell for assistance when he needed to transfer or to ambulate was not an effective safety measure, given his ongoing memory problems, the family's nursing expert went on to say.

The jury in the Supreme Court, New York County, New York awarded the family $275,000 for the patient's pain and suffering. **O'Dea v. Cardinal Cook Care Ctr., 2010 WL 3232844 (Sup. Ct. New York Co., New York, June 29, 2010).**

Elopement: Hospital Settles For Dementia Patient's Death.

The eighty-eight year-old patient was taken to the hospital by her son after he found her sitting in his own back yard in a confused mental state.

After a week in the hospital she was sent to a nursing home. She remained at the nursing home three months before being sent back to the hospital.

On admission to the hospital this time it was noted she had had a stroke and she was diagnosed with dementia and normal pressure hydrocephalus, all of which would tend to account for her diminished level of mental awareness.

Even before she left the hospital's E.R. it was already documented in her chart that she had become agitated and did not want to stay in bed, had tried to remove her own hep lock and climb out of bed and appeared to be a risk to herself. A vest restraint system was started for her in the E.R. before she was transferred to a med/surg unit.

Two days later an interdisciplinary plan of care was formulated. High on the problem list was the fact the patient was "attempting to discontinue therapeutic interventions," meaning that the patient was trying as best she could to remove her vest and wrist restraints.

Care Plan Called For Restraints
Care Plan Was Not Carried Out

The same day the interdisciplinary plan of care was instituted, however, the patient's nurses discontinued her restraints, which went completely contrary to the care plan.

Early the next morning the patient's physical therapist noted that she was not in her Posey vest which she was not tolerating and that she had been placed in a recliner at the nursing station due to her increasing tendency to wander. An occupational therapy note an hour later placed the patient's location in her room.

The patient's son claimed later that he often found his mother wandering about the hospital unit when he came to visit her and that it seemed to him, although they were fully aware of her tendency to wander, that none of the patient's caregivers were making any attempt to deal effectively with the safety risk that posed.

At approximately 5:00 p.m. the elderly dementia patient turned up missing from the hospital's med/surg unit.

At 7:55 a.m. the next morning, December 3, she was found on the hospital roof dead from hypothermia.

An investigation traced her route away from the med/surg unit through a fire door which had no alarm, up a flight of stairs to the top floor, through a door to a mechanical room that was supposed to be locked and from there through a door to the roof that was also supposed to be locked and have an alarm.

COURT OF COMMON PLEAS
ALLEGHENY COUNTY, PENNSYLVANIA
July 23, 2010

The family's lawyers were able to dig up maintenance records which showed that a broken lock on the door from the stairwell to the mechanical room was reported but never fixed.

They also discovered that the hospital had been written up by state survey inspectors for twenty-four miscellaneous care-plan violations over a nine-month period.

It also surfaced that the hospital had experienced twenty to thirty episodes of patient elopement during the two years prior to this patient's death, without policies or procedures being updated or emergency drills being conducted to reeducate caregivers on the specific steps to take when a patient elopement was discovered.

The lawsuit filed by the son as probate administrator in the Court of Common Pleas, Allegheny County, Pennsylvania resulted in a $900,000 settlement paid by the hospital prior to trial. **Diggs v. UPMC Med. Ctr., 2010 WL 3233128 (Ct. Com. Pl. Allegheny Co., Pennsylvania, July 23, 2010).**

Feeding Tube: Patient's Death Tied To Nursing Negligence.

While undergoing rehabilitation after a stroke the patient developed swallowing problems and had to have a PEG tube inserted into his stomach.

A few days after he began bleeding at the tube insertion site he was transferred from the rehab facility to a full-service acute care hospital. Sixteen hours after the transfer he was taken to the operating room for an emergency endoscopy to find out what was going on with the PEG tube. During that procedure he arrested and died.

The patient's nurses at the rehab facility were held partially to blame for his death for failing to report the bleeding from the insertion site as well as his complaints of ongoing severe pain and progressive changes in his mental status. The bleeding was caused by the bolster holding the tube in the stomach being too tight and impinging on the epigastric artery

The jury in the District Court, Tarrant County, Texas awarded more than $5,000,000. **Chesser v. Lifecare Hosp., 2009 WL 6764150 (Dist. Ct. Tarrant Co., Texas, December 22, 2009).**

Hoyer Lift: Staff Were Not Trained.

The nursing facility reportedly had had problems with patients falling or being dropped during Hoyer lift transfers due to some staff members being unaware of how properly to secure patients in the sling before maneuvering them.

These incidents apparently did not lead to any steps being taken to provide in-service training to update the aides' skills prior to an eighty-two year-old patient being dropped in a transfer from one bed to another, resulting in a femur fracture.

The patient's lawsuit in the Court of Common Pleas, Luzerne County, Pennsylvania settled for $310,000. **Marinock v. Manor at St. Luke's, 2010 WL 3233125 (Ct. Com Pl. Luzerne Co., Pennsylvania, January 29, 2010).**

Emergency Room: Care Delayed For Dehydrated Child, Hospital Pays Settlement.

The parents brought their four year-old developmentally disabled child to the E.R. at 9:25 p.m. because he had been vomiting and running a fever.

At 9:50 p.m. a nurse got vitals, pulse 180, respirations 40, and sent him back to the waiting room. At 11:48 p.m. another nurse took his temperature. The E.R. physician saw him at 12:10 a.m. and ordered Tylenol and IV fluid stat. The nurse called the IV team because she did not know how to start an IV, who finally got there and started the IV at 1:10 a.m.

At 1:18 a.m. the child seized and arrested and then died within the hour.

A nurse got the child's pulse and respirations within twenty-five minutes but it took more than two hours for another E.R. nurse to get his temp.

After the physician ordered an IV it took the nurses another hour to see that it got started.

The child seized and arrested a few minutes later.

COURT OF COMMON PLEAS
ERIE COUNTY, PENNSYLVANIA
June 3, 2010

The parents' nursing experts faulted the E.R. nurses for a direct violation of the hospital's standing procedures which required a pediatric patient's vital signs, including temperature, to be taken immediately if a history of fever was reported, then for allowing an hour to go by before the stat IV was started and, lastly, for never giving the Tylenol.

The lawsuit filed in the Court of Common Pleas, Erie County, Pennsylvania resulted in a pretrial settlement of $1,000,000. **Palmer v. Saint Vincent Health Ctr., 2010 WL 3233037 (Ct. Com. Pl. Erie Co., Pennsylvania, June 3, 2010).**

Hypoglycemia: Testing Delayed, Nurses Blamed.

An emergency c-section was ordered by the mother's obstetrician due to the possibility the fetus was in distress during labor. The mother had noticed a decrease in fetal movement for three days. When she got to the hospital the monitor picked up a fluctuating fetal heart rate and showed non-reassuring tracings.

Right after delivery the baby was lethargic, showed poor tone and color and did not cry.

The nurses did not test the baby's blood sugar until two hours after birth. They got a reading of nearly zero, tested again several times, then sent a blood sample off to the lab for confirmation.

When the lab finally confirmed the result the nurses tried feeding the baby formula. When they eventually notified the physician IV glucose was started, but not before the blood glucose level had been basically zero for at least two hours.

The history and signs of possible hypoglycemia required immediate testing at birth and prompt action when an unacceptably low result was first obtained, the lawsuit filed on the child's behalf claimed.

A settlement of $3,500,000 was paid for the child's case filed in the US District Court, Middle District of Georgia, as compensation for cerebral palsy, spastic quadriparesis, microcephaly and psychomotor retardation. **Coleman v. US, 2009 WL 6764097 (M.D. Ga., January 28, 2009).**

Informed Consent: Nurse Implicated In Lawsuit.

The circulating nurse was named with the physicians in a lawsuit filed in the Superior Court, Somerset County, New Jersey, by a patient who lost 75% of his eyesight during pancreas transplant surgery, a known complication which was never communicated to him beforehand. The patient settled for $2,900,000. **Gessner v. Somer, 2010 WL 3232806 (Sup. Ct. Somerset Co., New Jersey, May 5, 2010).**

Skin Care: Lack Of Documentation Bolsters Patient's Case.

The sixty-two year-old patient developed decubitus ulcers on his buttocks while in the hospital recovering from hip replacement surgery.

He sued the hospital and four nurses who were hospital employees along with a fifth nurse who was the employee of a nurse staffing agency.

The hospital and the nurses defended by claiming they did turn the patient every two hours on schedule and that skin ulcers can develop even when patients are turned regularly as they should be.

The patient's lawyers, however, were reportedly able to point to the fact there was no documentation in the chart whatsoever of the patient ever being turned.

The jury in the Superior Court, Camden County, New Jersey returned a verdict totaling $1,750,000 and delineated specific percentages to be paid by the hospital itself and each of the individual nurses. **Pacitto v. Kaufman, 2010 WL 2894797 (Sup. Ct. Camden Co., New Jersey, June 23, 2010).**

Patient In Shock: Nurses Should Not Have Transferred.

The Court of Appeals of Texas accepted the expert testimony of a nurse and a physician who were highly critical of the decision of the nurses caring for an elderly patient in the hospital to call an ambulance to have her taken to another hospital, rather than notifying her physician of her condition.

The patient's physician, if he had been informed by the patient's nurses what was going on, could have stabilized her with vasopressors and IV fluids to raise her blood pressure while tests were done to determine why she was in shock, most likely from internal bleeding whose source needed to be pinpointed with an angiogram and corrected. **Tenet Hospitals v. Barnes, __ S.W. 3d __, 2010 WL 2929520 (Tex. App., July 28, 2010).**

Freedom Of Speech: Nurse's Statements Not Protected.

A registered nurse employed by the state department of corrections brought up the issue in a staff meeting that other nurses were continuing to dispense inmates' mental health medications under physicians' orders that had expired.

The nurse insisted the other nurses should, instead, schedule their inmate patients to see the prison psychiatrist or at least communicate with the psychiatrist to make sure that the patient should still be on the medication and obtain a current order.

The nurse was written up and eventually was terminated for unrelated incidents of alleged inappropriate interaction with other staff. She sued the department, claiming that she was really terminated in retaliation for voicing her concerns about inmates' expired medication orders.

An employee of a public agency has the right to speak out on matters of public concern and cannot suffer employer retaliation for doing so.

However, matters that are strictly within the scope of the employee's job responsibilities are not matters of public concern.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
July 21, 2010

The US District Court for the Middle District of Pennsylvania ruled that even if that was the reason behind her termination, Freedom of Speech applies only when an individual is speaking out on a matter of public concern. A nurse communicating with coworkers on the job about day-to-day patient-care issues is not speaking out on a matter of public concern and cannot sue for violation of a Constitutional right. **Cicchielo v. Beard, __ F. Supp. 2d __, 2010 WL 2891523 (M.D. Pa., July 21, 2010).**

Ativan Overdose: Nurse Was On Probation For The Same Violation Of Care Standards.

A nurse's license was placed on probation in one state for administering Ativan to a patient without a physician's order. Rather than complete the terms of his probation he moved to another state and found employment as a nurse.

Once hired he revealed the situation with his license to his nursing director but he was not terminated or reported to that state's or the first state's board of nursing. In fact, his director asked him to follow her to her new job at another hospital where she made him a charge nurse.

He again gave Ativan to a patient whose allergy to that medication was clearly and thoroughly documented in the chart and in the hospital's medication records, without a physician's order, and the patient died.

The hospital failed in its legal duty to hire nurses that are competent and fit for employment.

The hospital hired the nurse knowing he was on probation in another state and had not fulfilled the conditions of his probation.

No precautions were taken to ensure the nurse would not commit the same violations again.

COURT OF APPEALS OF TEXAS
July 28, 2010

In a very complicated opinion the Court of Appeals of Texas upheld a $1 million-plus verdict in favor of the family for the hospital's negligence. The hospital was responsible for the nurse manager's decision to hire a nurse on probation to practice at the hospital and thereby allow him to commit the very same offense again. **THI of Texas v. Perea, __ S.W. 3d __, 2010 WL 2952149 (Tex. App., July 28, 2010).**

Head Injury: Nurses Failed To Communicate Change In Status To Physician.

A young woman was in the hospital recovering from a closed head injury sustained in a motor vehicle accident

She was initially sent from the emergency department to the hospital's neurological intensive care unit, then transferred to the intermediate neurological unit.

On the afternoon of her second day in the hospital she began to show signs her pain level was increasing.

Her nurses were closely monitoring her Glasgow Coma Scale score. It was assessed at 13 at 4:00 p.m. but dropped to 9 shortly after 7:00 p.m. The physician was not notified until almost 10:30 p.m. by which time the patient was in very dire straights. The patient died the next day.

The doctor has the right to defend himself against allegations of malpractice.

It is within the physician's standard of care for the physician to rely on the patient's nurses to notify him of significant changes in the patient's status.

COURT OF APPEALS OF TENNESSEE
July 23, 2010

The Court of Appeals of Tennessee ruled in the physician's favor on the question of his own malpractice.

That is, a physician has the right to defend himself or herself by bringing in expert testimony that it is within the standard of care for a physician to rely on the hospital's nurses to advise the physician of significant changes in the patient's status which require immediate attention, as in this case.

The jury ruled the nurses' negligence was the cause of death. **Stanfield v. Neblett, 2010 WL 2875206 (Tenn. App., July 23, 2010).**

Unnecessary Procedures: Court Puts Responsibility On Nurses To Report Physician's Actions.

Thirteen patients have joined a lawsuit against the medical center alleging that the center's nurses, technicians and other staff in the cardiac catheterization lab "worked hand in hand" with a certain cardiologist and knew or should have known what he was doing.

The cardiologist is alleged to have performed a vast number of cardiac catheterization and stent placement surgeries based on dramatic overstatements of the findings from cardiac stress tests and diagnostic imaging studies.

The center's nurses and technicians participated in the allegedly unnecessary and non-indicated procedures and failed to prevent or report the physician's actions.

The lawsuit also faulted the medical center's physician credentialing committee for failing to stop the physician but instead rewarding him with larger time blocks in the cath lab.

The weight of legal authority is that nurses and other staff owe a legal duty to the patient under their care and to potential future patients to report the physician.

UNITED STATES DISTRICT COURT
MARYLAND
August 12, 2010

There has been no definitive ruling that the medical center or any of its nurses, physicians or other staff are guilty of any wrongdoing.

At this point in the litigation the US District Court for the District of Maryland has merely ruled that the allegations raised by thirteen patients would be valid grounds for a lawsuit, at least theoretically.

The patients' lawsuit has survived a major hurdle and they will get their day in court to see if they can prove their cases.

What Is the Nurse's Responsibility?

In its legal brief the medical center posed the following hypothetical question:

Assume that "Nurse Jones" knew or should have known at some point in time before each patient's procedure that this doctor regularly and repeatedly performed unnecessary procedures.

Does "Nurse Jones" owe a legal duty to the doctor's future, unidentified and unknown patients to report the concerns that "Nurse Jones" has?

The Court ruled, first of all, that the hospital's hypothetical question about future, unidentified, unknown patients is an attempt to dodge the real issue.

A nurse owes a duty directly to the patient currently under the nurse's care to report the nurse's concerns through appropriate channels if the patient undergoes an unnecessary medical procedure.

Secondly, for what it is worth, according to the Court, the simple answer to the hospital's hypothetical is "Yes."

Nurses who stood by silently yesterday or last year while unnecessary procedures went ahead would be responsible to today's patients whose safety is threatened by the behavior of a physician who was not reported and stopped from doing further unnecessary medical procedures.

The Court said there is no direct legal precedent in Maryland on the issue raised in this case, but courts in other US jurisdictions have imposed legal duty and legal liability on nurses under the same circumstances. **Baublitz v. Peninsula Regional Med. Ctr., 2010 WL 3199343 (D. Md., August 12, 2010).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Centers For Disease Control: New Vaccine Information Statements For Rotavirus, PCV, HPV, Influenza, MMR, MMRV.

On August 11, 2010 the US Centers for Disease Control and Prevention (CDC) published four separate notices in the US Federal Register announcing the availability of new or revised vaccine information materials for a number of vaccines.

The CDC is accepting public comments until October 12, 2010.

Covered by the announcement are rotavirus vaccine, pneumococcal conjugate vaccine, human papillomavirus vaccine, trivalent influenza vaccine, measles, mumps, varicella vaccine and measles, mumps, rubella, varicella vaccine.

The CDC's current approved vaccine information materials provide information to healthcare providers on the CDC's latest recommended immunization schedules, contraindications for the vaccines and what to do in the event of an adverse reaction.

A copy of the CDC's current vaccine information statement must be provided to the patient or adult guardian of the pediatric patient at the time the vaccine is administered.

Vaccine Information Statements Available Online

All of the CDC's vaccine information statements are available for free download from the CDC website www.cdc.gov/vaccines/pubs/VIS.

The CDC website tells how to obtain non-English language versions of the vaccine information statements and electronic versions for email and transmission to portable devices.

Additional information can be obtained by accessing the CDC's four August 11, 2010 Federal Register announcements which we have placed on our website:

www.nursinglaw.com/rotavirus.pdf

www.nursinglaw.com/PCVHPV.pdf

www.nursinglaw.com/trivalentinfluenza.pdf

www.nursinglaw.com/MMRMMRV.pdf

FEDERAL REGISTER August 11, 2010
Pages 48706 - 48719

Labor And Delivery: Prompt Cesarean Not Done, Jury Places Blame On Hospital's Nurses.

The parents filed a lawsuit on behalf of their child who now suffers the effects of brain injury at birth, neuromuscular, cognitive and intellectual dysfunction and blindness.

The parents' lawsuit named as defendants the mother's own obstetrician, two obstetricians who actually delivered her baby vaginally at the hospital and the hospital itself as the employer of the labor and delivery nurses who cared for her during her labor.

As the scenario developed, the fetal monitor was reportedly showing signs of fetal distress. The mother's obstetrician was notified but was unaccountably delayed getting to the hospital.

At this point, it was alleged in the lawsuit, the labor and delivery nurses should have taken steps promptly to get assistance from another physician.

The mother sued her own obstetrician, the two physicians who delivered her baby and the hospital itself as the employer of the labor and delivery nurses.

The jury found the hospital 100% at fault for the baby's brain injury.

The nurses did not find another physician promptly when the mother's ob/gyn was delayed getting to the hospital.

DISTRICT COURT
SEDGWICK COUNTY, KANSAS
March 26, 2010

Two physicians did eventually step in and perform a difficult forceps delivery. The lawsuit alleged, however, that they performed the forceps delivery negligently, should have performed a cesarean instead and that the cesarean itself should have been started much sooner than it was.

The jury in the District Court, Sedgwick County, Kansas returned a verdict of $2,404,427.12 for the baby's past and future medical expenses.

The jury expressly found the hospital 100% at fault and the mother's obstetrician and the physicians who delivered the baby not at fault. Realizing the need for prompt medical intervention, the nurses should not have waited for the mother's physician but should have found backup assistance. **L.U. v. Montoya, 2010 WL 3261182 (Dist. Ct. Sedgwick Co., Kansas, March 26, 2010).**