LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

September 2011 Volume 19 Number 9

E.R.: Hectic Conditions Taken Into Account In Defining The Standard Of Care, Court Says.

The patient arrived in the hospital's emergency department at 5:50 p.m. on New Year's Day. He told the admitting desk clerk his heart was racing.

The patient died in the E.R. less than two hours later that evening from sudden cardiac death related to severe hypertensive heart disease and an enlarged heart.

The Supreme Court of Mississippi ultimately ruled the hospital was not liable in the family's wrongful death lawsuit, stating in part that the conditions in the E.R. that evening resembled a "mass casualty situation."

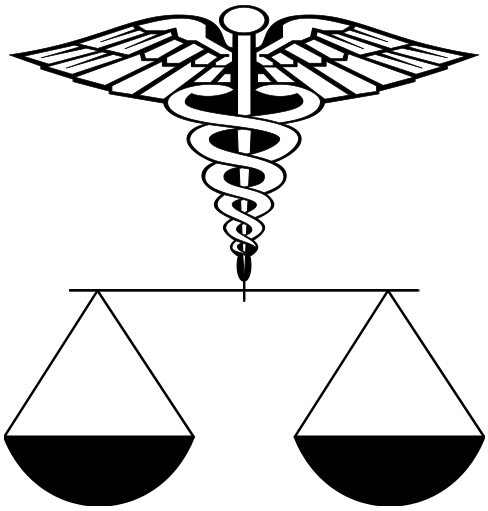
Patient's Presentation

An emergency medical tech took the patient's vital signs within ten minutes. The patient told him his chest was sore, but the patient, when asked, denied feeling pressure, radiating pain, sharp or dull pain in his chest.

The patient did not seem to be in distress, was not short of breath and was not sweating.

The tech passed a sticky note on to the E.R. nurse. The nurse believed that an EKG and advanced cardiac life support were not necessary because the patient was basically stable.

Another nurse came in a few minutes later an hour early for her 7:00 p.m. shift and saw that she needed to get to work right away.



The E.R. nurse's triage of this patient was a reasonable preliminary screening, given the symptoms he reported, the way he appeared and what else was going on in the emergency department at the time.

The standard of care depends upon the circumstances and the options that are available at the time to the patient's caregivers.

SUPREME COURT OF MISSISSIPPI
July 21, 2011

The first thing she did was ask those in the waiting room who felt they needed to be seen immediately. Four raised their hands, but not this patient.

The first nurse checked back and saw the patient in question laughing and talking with other patients. A few minutes later, however, someone screamed. The nurse and the E.R. physician went and got the patient on a stretcher and moved him into an examination room. He was in v fib. The code team was unable to revive him.

Legal Standard of Care Not Violated

The trial of the family's lawsuit was a classic "battle of the experts." The judge credited the testimony of the experts who testified for the hospital that it was necessary to take into account the hectic situation in the E.R. as a relevant factor in what the law expected of the patient's caregivers.

Hospital policy setting out everything that was to be done with every identified cardiac patient was not absolute, only one factor to be considered.

It was not clear from the autopsy that the patient died from an acute coronary event. Troponin was detected in the blood, but that could have been a result of heart compressions during CPR, the Court said. **Estate of Sykes v. Calhoun Health, __ So. 3d __, 2011 WL 2899642 (Miss., July 21, 2011).**

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September 2011

New Subscriptions See Page 3

Disability Discrimination: No Basis For E.R. Patient's Suit, Court Says.

The patient came to the hospital's E.R. complaining of abdominal pain.

He was seen by the triage nurse within minutes of arrival. He reported his pain was 9/10 and the nurse obtained and charted a history of pancreatitis and peptic ulcer disease.

Soon after being led to an exam room to which he ambulated without assistance he was asked to put on a hospital gown. He refused. Over the course of the next few hours he remained hostile and combative. Hospital security was called.

The E.R. physician got him to take off his shirt for an IV and a CT, but the CT had to be cancelled when the patient refused to swallow the oral contrast medium.

The nursing supervisor finally convinced him to change into the hospital gown, but he soon changed his mind, put his shirt and jacket back on and left AMA.

The patient sued the hospital for disability discrimination. He claimed his disability was an unusual sensitivity to cold which prevented him from changing into a hospital gown and the hospital thus discriminated against him by trying to get him to change into the gown.

The hospital countered the lawsuit with testimony from the E.R. nurses that it was standard policy to have all patients change into a hospital gown to be examined and that the patient was offered a total of three warmed blankets.

The Patient Was Not Disabled

The US District Court for the Eastern District of California ruled that both sides' testimony was beside the point. The Court dismissed the case on the grounds that the patient failed to prove he had a disability as disability is defined by the US Americans With Disabilities Act (ADA).

Places of Public Accommodation
Americans With Disabilities Act

The Court took the occasion to outline a hospital's legal responsibilities under the ADA, a hospital being a place of public accommodation covered by the ADA .

The first point is that the definition of disability is interpreted by the courts in favor of inclusion rather than exclusion. Nevertheless, disability has its own meaning under the ADA and the common dictionary definition is not the answer.

The patient has not proven that he was disabled within the meaning of the Americans With Disabilities Act.

UNITED STATES DISTRICT COURT
CALIFORNIA
August 12, 2011

Definition of Disability

Disability is a physical or mental impairment that substantially limits one or more major life activities.

A physical or mental impairment is any physiological disorder or condition, cosmetic disfigurement or anatomical loss affecting the body's neurological or musculoskeletal systems, special sense, respiratory, cardiovascular, reproductive, digestive, genitourinary, hemic, lymphatic or endocrine organs or skin, or any mental or psychological disorder such as mental retardation, organic brain syndrome, mental or emotional illness or a specific learning disability.

Federal regulations expand the ADA's basic definition of disability to include contagious and non-contagious diseases, orthopedic, visual, speech and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, HIV (symptomatic or non-symptomatic), tuberculosis, drug addiction and alcoholism.

Disability Discrimination
Failure to Make
Reasonable Accommodation

Discrimination includes failure to make reasonable modifications in policies, practices or procedures when such modifications are necessary to afford services to individuals with disabilities, unless the facility can demonstrate that making such modifications would fundamentally alter the nature of such services.

It is discriminatory to deny an individual or class of individuals the opportunity to participate in or benefit from the facility's services.

The first question for the Court still is, however, whether the person has a disability. **Tater-Alexander v. Amerjan, 2011 WL 3568026 (E.D. Cal., August 12, 2011).**

E.R.: Intoxicated Patient Turned Away, Nurses Seen Responsible.

The nurse practitioner who was the senior nurse on duty in the hospital's E.R. received a phone call at 2:15 a.m. in the doctor's lounge from one of the nurses. The nurse was in the parking lot with police officers who had an intoxicated individual in the back seat of their patrol car and wanted to know what to do.

Without going out to check on the man the nurse practitioner reportedly just told the nurse she knew of no other cure for drunkenness except to sleep it off. The best they could do was have him come in and start an IV, but that would really not help. The police took him to the jail.

At 10:10 a.m. they brought him back. This time he was dead from cardiac arrest.

It is common knowledge that alcohol poisoning can lead to serious injury or death if it is severe enough. The patient, at a bare minimum, should have been admitted for blood alcohol tests to determine the seriousness of his intoxication.

UNITED STATES DISTRICT COURT
MISSISSIPPI
August 16, 2011

The US District Court for the Northern District of Mississippi believed there were strong grounds for a lawsuit by the family implicating both nurses for negligence.

The issue for the Court at this time was trying to sort out which experts to allow to testify in the trial. One side's experts claimed the deceased would have been saved by competent E.R. care. The other side claimed he was so intoxicated at the point he was brought to the hospital that nothing could have been done to save him. Neither side's case will be easy to prove definitively with the evidence available. **Flax v. Quitman County Hosp., 2011 WL 3585870 (N.D. Miss., August 16, 2011).**

Patient's Fall: Court Finds Grounds For Suit.

When the patient was admitted to the hospital for hypoglycemia he was not able to walk or even answer questions posed to him. The Morse Fall Risk Assessment done on admission concluded he was a high fall risk.

The same day he was admitted he managed to remove his condom catheter, which required an aide to come to the room and remake the bed completely. An hour later he was found on the floor with a fracture of his right tibial plateau.

The hospital asked for dismissal of the family's lawsuit on the grounds there are no recognized standards in the medical community for fall prevention.

The family countered with the written opinion of a registered nurse with forty-five years patient-care experience whom the US District Court for the Western District of Kentucky accepted as an expert.

The aide who remade the bed did replace the condom catheter but apparently neglected to attach it to the tubing to the collection bag and neglected to turn the bed alarm back on. It also would have been appropriate, in light of the patient's high fall risk, for him to have been placed in a room near the nurses station for closer observation. **Milby v. US, 2011 WL 3585632 (W.D.Ky., August 15, 2011).**

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Dental Procedure: Nurse Gave Pediatric Patient Fatal Overdose.

The patient, almost two years old, underwent dental surgery at an ambulatory surgical center under general anesthesia.

In the post-surgical recovery area he was prescribed morphine prn for pain. The nurse reportedly gave the child two .5 mg doses.

Six hours later his grandmother found him unresponsive. He was rushed to the hospital by paramedics. After sixteen days in a coma his family agreed to discontinue the respirator and he died.

For a 13 kg pediatric patient the recommended dosage range for morphine would have been .26 mg to .65 mg, far less than the 1 mg that was administered.
COURT OF APPEALS OF TEXAS
August 10, 2011

The Court of Appeals of Texas pointed to the expert opinion of the anesthesiologist retained by the family's lawyers as an expert. He delineated the acceptable pediatric dosages for morphine and stated than the excessive dosage ordered by the dentist and given by the nurse were, more likely than not, the cause of death. **Seastrunk v. Meza, 2011 WL 3502272 (Tex. App., August 10, 2011).**

Home Health: Agency Held Liable For Overdose.

The patient's PCA morphine pump was hooked up by a nurse from the home health agency at 4:00 p.m. the afternoon of her discharge from the hospital following orthopedic surgery. The patient gave herself the maximum boluses right away.

At 6:48 p.m. the patient's mother called the agency to ask when the nurse was coming. She was told someone would be there by 10:00 p.m. At 7:54 p.m. the mother called 911. Paramedics arrived four minutes later and found the patient unresponsive. Narcan was given and she was transported to the hospital, but she nevertheless suffered hypoxic brain injury.

The California Court of Appeal ruled there were grounds for a negligence lawsuit against the home health agency.

The physician's discharge orders specified twice-daily nurse visits for the first seven days. At each visit the nurse was to remain in the home at least thirty minutes, ambulate the patient and check temp, BP, pulse and respirations.

Regardless of the nursing agency's own policies as to whether the orders started the first day and whether the initial hookup counted as a nurse visit, there should have been two more nurse visits on the first day, because the physician's orders said so. If there had been two visits that afternoon and early evening the overdose would have been caught in time, the Court said. **Pritchard v. Coram Healthcare, 2011 WL 3211536 (Cal. App., August 2, 2011).**

Post-Op Nursing Care: Court Says Standard Of Care Not Followed.

After a vaginal hysterectomy the forty-five year-old patient was taken to the recovery room where she began having difficulties.

She was eventually diagnosed with hemorrhagic shock and returned to the O.R. for surgical repair of the source of her internal bleeding.

She died five hours after this second surgery. The autopsy report stated she died as a result of complications of acute hemorrhagic shock due to post-operative bleeding and morbid obesity with hepatomegaly, severe fatty metamorphosis and early fibrosis.

Opinions of Ob/Gyn On Nursing Standard of Care

The Court of Appeals of Texas ruled that the family's expert witness, an ob/gyn physician, was qualified to give an opinion on what a hospital's nurses must do but was not qualified to state how a hospital is required to train its nurses, but that was still enough for the lawsuit to go forward.

The physician had worked for many years with nurses and nurse practitioners in the hospital setting caring for surgical ob/gyn patients. It is not always true that an witness must be a nurse in order to be qualified to render an opinion on the nursing standard of care.

The hospital's nurses failed to monitor the blood loss that the patient experienced during surgery and afterward failed to recognize her compromised status in the post-anesthesia recovery room.

The patient continued to receive pressor medication when the medication was contraindicated and should have been stopped and the surgeon who had done the surgery or another surgeon was not contacted until it was too late, the Court said.

If the second surgery had been done promptly, in the patient's expert's opinion, the source of the patient's post-operative bleeding could have been identified and corrected and the patient, more likely than not, would have survived.

The Court's decision did not outline in specific terms the signs that were present in this patient's case or define the precise clinical parameters that indicate specifically when nurses are required to act. **Columbia North Hills Hosp. v. Alvarez, 2011 WL 3211239 (Tex. App., July 28, 2011).**

The legal standard of care for the hospital and its nursing staff caring for this patient in the post-anesthesia care unit and the critical care unit was to recognize an emergent and critical post-operative bleed and to invoke the chain of command to make sure the patient was returned to surgery in a timely fashion.

Post-operative management of the patient was negligent in that the nurses watched her decline throughout the day without effectively utilizing the chain of command.

They should have communicated the emergency nature of the situation to the surgeon, then quickly gone up the chain of to get senior nursing personnel to the bedside.

The assistant CNO and the nurse case manager eventually came to the patient's room that evening, but they should have been summoned and arrived much sooner.

The surgical nurses were also required by the applicable standard of care to properly evaluate the operative blood loss. These nurses were negligent in that they grossly underestimated loss of approximately 4800 cc's.

COURT OF APPEALS OF TEXAS
July 28, 2011

Medicaid: New Eligibility Standards For 2014.

On August 17, 2011 the US Centers for Medicare and Medicaid Services (CMS) announced proposed new Medicaid eligibility standards that will take effect January 1, 2014.

The new standards are intended to implement the changes enacted by last year's healthcare reform legislation known as the Patient Protection and Affordable Healthcare Act of 2010.

CMS's announcement from the Federal Register is on our website at http://www.nursinglaw.com/CMS081711.pdf

FEDERAL REGISTER August 17, 2011
Pages 51148 - 51199

DNR: Patient Was Resuscitated, Family Can Sue.

The Court of Appeal of Louisiana ruled that the family has the right to sue for the fact that the Do Not Resuscitate (DNR) order in their elderly father's medical chart was ignored when he went into cardiac arrest in the hospital.

The patient lingered in the hospital more than two months. The family's lawsuit claimed damages for medical expenses for post-resuscitation care and for the deceased's physical and mental pain and suffering, loss of enjoyment of life and cognitive decline.

The issue for the Court at this point was whether failing to honor a DNR order is medical malpractice which in Louisiana requires the filing of a claim with the State Patient's Compensation Fund and the convening of a medical review panel of physician experts to rule on the case, or is ordinary negligence for which the aggrieved parties can go straight to court.

The Court ruled it is not medical malpractice and gave the family an expedited track to their day in court. **Jones v. Ruston Louisiana Hosp. Co., __ So. 3d __, 2011 WL 3477170 (La. App., August 10, 2011).**

Restraints: Nurse Was Wrongfully Terminated.

A registered nurse was terminated from her position for alleged patient abuse and failure to follow nursing standards and facility policy after leading a team of state psychiatric hospital staff members who were restraining a combative adult patient known to spit, bite, head butt and hit his caregivers.

The psychiatric facility's personnel were told during an in-service that the head was never to be held while restraining a combative patient who was acting out. However, there never was a formal written policy to that effect put on the books.

MISSOURI COURT OF APPEALS
August 9, 2011

The Missouri Court of Appeals ruled that her termination was not justified.

The facility's written policy prohibited use of any restraint technique that interfered with breathing such as choking, covering the mouth or nose with a towel or other items or sitting on the chest.

It appeared on the video record of the restraint incident that the nurse was mainly concerned with keeping the spit mask in place and preventing the mask from interfering with the patient's breathing while other staff members focused on holding and strapping down the patient's arms and legs. She may have momentarily placed her hands over the mouth and nose.

While the incident went down the patient was almost constantly screaming and yelling, evidence that his ability to breathe was never being compromised.

It was not justifiable to find a nurse incompetent for not following an oral directive from a presenter in an in-service training on patient restraints that was never incorporated formally into written facility policy, the Court said. **Henry v. Missouri Dept. of Mental Health, __ S.W. 3d __, 2011 WL 3444057 (Mo. App., August 9, 2011).**

Misconduct: Irregularities In Reporting Hours Grounds For Nurse's Firing.

A registered nurse was terminated by the hospital for time card violations, after ten years of employment.

The nurse lost and never replaced the badge that hospital employees used to record and make adjustments on the hospital's timekeeping system. He could still access the hospital computer system over the phone and turn in adjustment forms.

He submitted the adjustment forms claiming pay at the charge-nurse rate when he actually worked two days' shifts as a staff nurse. For those two days he also actually clocked out earlier than what he reported on the pay forms.

The next day he did not work at all due to a scheduling change but he had already sent in the form for a day's charge-nurse pay. He later claimed it was someone else's job to correct the information.

A few days later he attended a continuing education program but left an hour early after a phone call about a family emergency. He was entitled to be paid, but only for the time he was actually there. He never corrected the full day's pay request he had submitted ahead of time.

Employment misconduct is any intentional, negligent or indifferent conduct which is a serious violation of the standards of behavior the employer reasonably has the right to expect, or a substantial lack of concern for the employment.

COURT OF APPEALS OF MINNESOTA
August 15, 2011

The Court of Appeals of Minnesota ruled the hospital had the right to terminate the nurse for employment misconduct and he was therefore not eligible to receive unemployment benefits. **Barott v. Alina Health, 2011 WL 3557839 (Minn. App., August 15, 2011).**

Alcohol Test: Court Says Nurse Can Sue For False Positive Result.

After admitting to alcohol dependency a registered nurse agreed to participate in her state nursing board's nurses' assistance program as a condition of maintaining her license.

The nursing board used an outside vendor for urine alcohol screening of assistance-program participants which relied on ethyl glucuronide lab testing.

According to the Supreme Court of Kansas, published scientific literature began to suggest in 2004 that use of certain products that contain alcohol, such as hand sanitizers widely used in healthcare settings, can lead to false-positive results. In 2006 the US Substance Abuse and Mental Health Administration issued an advisory to the effect that this test was a valuable clinical tool but should not be used as the primary or sole evidence in a criminal justice or regulatory compliance context that an individual prohibited from drinking has been drinking.

The nurse's lawsuit alleged the nursing board's outside vendor was negligent in establishing arbitrary and scientifically unreliable standards for test results which were reported as positive due to incidental or involuntary exposure to a common product containing alcohol.

SUPREME COURT OF KANSAS
August 12, 2011

According to the Court, it should have been foreseeable to the board's outside vendor that use of an unreliable alcohol test could lead to an individual wrongfully losing her nursing license and wrongfully being dismissed from employment, as happened in this case. **Berry v. National Medical Services, __ P. 3d __, 2011 WL 3524112 (Kan., August 12, 2011).**

Discrimination: Court Accepts Nurse's Fatigue As A Disability.

A sixty-five year-old hospice nurse sued her former employer after her termination, alleging disability and age discrimination.

The US District Court for the Western District of Washington was disturbed by a large number of derogatory emails exchanged by her managers before she was terminated that seemed to suggest a coordinated, almost conspiratorial effort to trump up a groundwork of complaints so she could be fired. The emails boomeranged on the managers by tending to show a pattern of personal animosity toward the nurse in question, in the Court's view.

A disability is a physical or mental condition which interferes in a significant way with a major life activity.

Working is a major life activity.

UNITED STATES DISTRICT COURT
WASHINGTON
August 15, 2011

With a medical history that included an aneurysm and breast cancer, the nurse had told her managers she nevertheless was able to do her job as long as she got enough rest.

Disability, for purposed of the US Americans With Disabilities Act, includes conditions which are disabilities as well as conditions which are perceived as disabilities by the employee's supervisors.

No Age Discrimination

The nurse, sixty-five at the time of firing, was replaced in her former position by a fifty year-old nurse, which in and of itself did not prove discriminatory intent.

The Court pointed out that nurses at the facility were mostly between fifty and fifty-three. The newly-hired nurse was younger, but was herself in the age bracket that is protected by the age-discrimination laws. **Knodel v. Providence Health, 2011 WL 3563912 (W.D. Wash., August 15, 2011).**

Discrimination: Patient-Care Reassignment Did Not Create Hostile Environment.

A minority aide reported to her manager that she suspected one of the nursing facility's long-term residents of illicit use of marijuana based on a strong smell present in the room.

The charge nurse investigated and confiscated a bag of an unspecified substance from the resident.

The aide complained again about suspected drug use by the same resident. This sparked a confrontation with the staff nurse assigned to the patient who strenuously insisted that the aide leave the resident alone and mind her own business. Afterward the aide's assignments were changed so that she was no longer assigned to care for the resident in question.

Another resident was added to her list, an elderly woman with dementia well known for lashing out verbally with racist comments toward minority caregivers.

A hostile work environment amounts to racial discrimination when the employer creates an objectively hostile or abusive work environment that is humiliating or physically threatening.

UNITED STATES DISTRICT COURT
NEW YORK
July 28, 2011

The US District Court for the Western District of New York was not convinced that having the aide work with an elderly demented racist fell within the definition of a racially hostile work environment.

The Court believed facility management was merely making a legitimate effort to defuse the hostility between the aide and the first patient's nurse and there was no motive to retaliate against the aide based on her race. **Wright v. Monroe Community Hosp., 2011 WL 3236224 (W.D.N.Y., July 28, 2011).**

Perforated Ulcer: Staff Members' Incompetence Led To Patient's Death.

The patient was a twenty-one year old woman afflicted with cerebral palsy, mental retardation and neuromuscular scoliosis who lived in a private, non-profit facility for the developmentally disabled.

Her mother, while visiting, became concerned and requested that someone contact the physician. He prescribed Phenergan and acetaminophen, which was never administered.

That evening she vomited, became weak, pale and sweaty and her abdomen became distended. A nurse came in during the night. When she left the next morning the nurse explicitly told the staff to contact her if the patient vomited again.

Later that morning the patient vomited again, but the staff members did not contact the nurse. Another nurse came in later that day and did nothing until the patient was not breathing and had no pulse. At that point 911 was called.

The patient died in the hospital that day from sepsis related to a perforated gastric ulcer.

The caregivers' failure to follow the nurse's direction to call her if the patient vomited raises a legitimate question whether they were suitable for the task of monitoring individuals with mental retardation.

SUPERIOR COURT OF PENNSYLVANIA
July 22, 2011

The Superior Court of Pennsylvania ruled that the failure of the facility's staff to contact the nurse as they were told when the patient vomited colored liquid that morning amounted to incompetence and gross negligence.

It was also problematic for the Court why the nurse who did come in to see the patient failed to start CPR and waited so long to call 911. **Potts v. Step By Step, Inc., __ A. 3d __, 2011 WL 2937397 (Pa. Super., July 22, 2011).**

Spoliation Of The Evidence: Court Lets Patient Sue.

The next day after the patient was admitted to the hospital in labor she gave birth by cesarean to an infant that had been in breech position inside her uterus.

The child has suffered from numerous medical and developmental issues the parents believe were caused by substandard nursing care during the mother's labor and/or at the time of delivery. They filed a lawsuit against the hospital.

After the parents' malpractice suit was filed the hospital claimed certain records could not be located, including the nursing notes, labor and delivery flow sheets, fetal heart monitor strips and the perioperative nursing notes from the patient's c-section.

SUPREME COURT OF INDIANA
August 10, 2011

In the first phase of the lawsuit, called civil discovery, the parents' lawyers made a formal demand for all of the pertinent medical records from the hospital.

The hospital countered with an affidavit that the records could not be located.

The parents' expert neonatologist then issued a statement that he could not formulate an opinion on the professional negligence issues without the missing records.

The parents' lawyers then amended the lawsuit to include allegations against the hospital of spoliation of the evidence, that is, intentional or negligent action by the hospital which caused alteration or loss of evidence that would allow the parents to succeed with a lawsuit against the hospital.

The Supreme Court of Indiana agreed in general terms that spoliation of the evidence is a valid basis for a lawsuit, but such allegations are not separate from the healthcare malpractice lawsuit and must go through a pre-suit medical review panel, a technicality of Indiana state law. **Howard Regional Health v. Gordon, __ N.E. 2d __, 2011 WL 3501882 (Ind., August 10, 2011).**

EMTALA: Hospital Did Not Follow Standard Screening For Pregnant Patient, Grounds Seen For Lawsuit.

The US Emergency Treatment and Active Labor Act (EMTALA) does not expressly set the parameters of an appropriate medical screening examination in the emergency department.

The courts have decided that the patient can sue the hospital if the screening examination failed to comply with the standard screening protocol that the hospital regularly follows for other patients presenting in the emergency department with the same or substantially similar signs and symptoms.

There is no dispute that the hospital had in place a "Gravid with 3rd Trimester Bleeding" protocol which explicitly required a speculum vaginal examination if the patient was bleeding.

Moreover, the protocol in question specified that certain laboratory studies be performed, including CBC, urinalysis, serology, platelet count and other tests.

This patient did not get a vaginal speculum examination or lab tests required by the hospital's standing protocol for third trimester bleeding that would have pinned down the problem.

UNITED STATES DISTRICT COURT
PUERTO RICO
August 15, 2011

The patient gave birth to a premature baby girl whose incomplete development resulted in respiratory complications that led to the baby's death two days after she was born.

She came to the hospital's E.R. at 10:15 p.m. with complaints of vaginal discharge and occasional blood spotting within the previous half hour. She denied pelvic pain, dysuria or fever and she was feeling fetal movements.

The E.R. physician phoned and spoke with her ob/gyn at 10:55 p.m. The plan was to give terbutaline and Vistaryl and discharge her with instructions to come to the office first thing the next morning. She was discharged at 12:15 a.m.

She saw the ob/gyn shortly after 8:00 a.m. Soon after examining her the ob/gyn was on the phone arranging for admission at another hospital where the infant was delivered by cesarean at 12:12 p.m. with low APGAR's and a weight of 2 lbs 14 oz.

Hospital's Standard Screening Not Followed / EMTALA Violation

The US District Court for the District of Puerto Rico said the first hospital violated the US Emergency Medical Treatment and Active Labor Act (EMTALA).

The first hospital's standing protocol for "Gravid with 3rd Trimester Bleeding" required a vaginal speculum exam to differentiate bleeding from bloody show and rule out placentia previa, abruption or rupture of the membranes. The gestational age was to be determined, maternal vital signs taken and fetal heart tones measured by Doppler.

In addition, lab work was supposed to include a CBC along with other testing. According to the patient's medical expert, a CBC in the E.R. that night would have revealed that the patient's pre-term labor at 27+ weeks was due to a decidual or placental infection.

The patient reportedly was only given a cursory pelvic exam and sent home with medications. The protocol for third-trimester bleeding was not even minimally carried out. **Cruz-Vazquez v. Mennonite Gen. Hosp., 2011 WL 3607669 (D. Puerto Rico, August 15, 2011).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Power Of Attorney: Daughter Did Not Have Authority To Sign Arbitration Agreement.

The elderly patient died shortly after discharge from a month-long stay in a skilled nursing facility, and the family decided to sue.

Before getting to the allegations of negligence raised in the family's lawsuit, the facility's first line of defense was to petition the court to dismiss the lawsuit from the jury-trial docket and refer the case to out-of-court arbitration where the facility's lawyers believed they would obtain a more favorable outcome.

The patient's daughter signed an arbitration agreement at the time of her mother's admission to the facility. The patient had already named the daughter as her surrogate in a durable power of attorney the patient had signed well before her admission to skilled nursing.

The patient's power of attorney stated that, whether or not the patient still had the capacity to make her own decisions, her daughter was empowered to make any and all healthcare decisions for her as her healthcare surrogate. More specifically, the surrogate was empowered to consult with health care providers, sign informed consent documents, apply for Medicare, Medicaid and other insurance benefits, have access to personal financial information, have access to confidential medical records and billing information and withdraw life-prolonging or death-delaying medical procedures.

The power of attorney, however, made no express mention whatsoever about arbitration of disputes with health care providers.

The District Court of Appeal of Florida noted at the outset of its decision that arbitration is the preferred method of resolving liability disputes between patients and health care providers, but if and only if the patient or someone duly authorized to speak for the patient agrees.

An agreement to arbitrate must be in writing and it must be signed by the patient or an authorized surrogate with an understanding of what is being agreed upon. A surrogate's authority to sign an arbitration agreement under a power of attorney must be clearly spelled out in the power of attorney. A catch-all grant of miscellaneous legal powers is not sufficient, the Court said.

In short, the facility should have had the patient herself sign the arbitration agreement along with the other admission papers. **Estate of Irons v. Arcadia Healthcare, __ So. 3d __, 2011 WL 3300218 (Fla. App., August 3, 2011).**

Abandonment: Court Refuses To Dismiss Home Health Nurse's Wrongful Termination Lawsuit.

An RN employed by a nursing agency was providing twice-weekly wound care to a homebound patient pursuant to an order from the patient's physician.

The nurse was told by his supervisor to discontinue the patient's care immediately. The reason which came to light later was that the company had decided it was leaving the business of providing home health care.

The nurse was fired for alleged insubordination after he continued going to the patient's home and providing wound care because he believed the physician's order was still in effect.

He believed it would be illegal patient abandonment to cease taking care of her until arrangements were made to continue her nursing care or the physician ordered it discontinued.

The nurse claimed in his lawsuit that, if he had followed orders from his employer to discontinue the patient's care, he would have violated the state's nurse practice law.

If an employer fires an employee for a reason that violates a clear mandate of the law, the terminated employee has the right to sue the former employer for wrongful termination.

UNITED STATES DISTRICT COURT
SOUTH CAROLINA
July 25, 2011

The state's nurse practice act prohibits a nurse from abandoning a patient without making sure that arrangements are made for continuation of care after accepting a patient assignment and establishing a nurse/patient relationship with a patient.

The US District Court for the District of South Carolina agreed with the nurse. As a general rule an employee can be terminated at the will of the employer if the employee does not have rights under an employment contract or a union collective bargaining agreement. However, a major exception to the general rule has been carved out by the courts to protect an employee who is terminated for refusing to follow an order from the employer which would amount to a clear violation of the law. **Patterson v. Gentiva Health, 2011 WL 3235466 (D.S.C., July 25, 2011).**