// LEGAL EAGLE EYE NEWSLETTER

September 2012 *For the Nursing Profession* Volume 20 Number 9

# Emergency Room Discharge: Court Sees Grounds For Patient's Suit Against Hospital.

The seventy-four year-old patient arrived by herself at the hospital's emergency department complaining of chest pain.

She informed her caregivers she had a history of gastrointestinal reflux disease.

She also shared the fact she had taken Ambien and Klonopin the night before to help her sleep.

Treatment consisted of IV Benadryl and Pepcid for what were diagnosed as gastrointestinal symptoms. After six hours her condition had improved and she was ordered discharged.

When she was told it was all right for her to leave, the patient asked her nurse to phone her son to come and pick her up because she was not feeling well. The nurse phoned the son as the nurse was asked.

**Patient Sent Down Corridor To E.R. Ambulance Entrance**

The patient was then pointed down a hospital corridor leading outside from the emergency department.

The corridor was the one used by ambulance crews to bring in patients on stretchers. At the end of the corridor was a double set of doors which opened toward the inside.

When the patient pushed the button the doors opened inward toward her. She was knocked down and injured.

***Given the known potential side effects of Benadryl to cause dizziness and drowsiness and its potentiated effect on the elderly, the patient should have been personally assisted by hospital staff upon discharge or her condition should have been re-evaluated immediately prior to discharge from the hospital's emergency department.***

NEW YORK SUPREME COURT
APPELLATE DIVISION
August 8, 2012

**Hospital Staff Should Have Assisted the Patient**

The New York Supreme Court, Appellate Division, ruled there were legal grounds for the patient's lawsuit against the hospital.

The hospital's expert's opinion was that the general procedures in effect in the emergency department complied with the applicable standard of care and the hospital's doors were in no way mechanically defective.

The Court, however, was swayed in the patient's favor by the patient's expert's opinion that the patient should have been assisted in person by the hospital staff until she was safely out of the hospital and had met up with her family member.

The hospital nurses should have taken into account the known side effects of the medications the patient was administered in the emergency department as well as those she had taken at home which were noted in her chart at the time of her initial assessment.

These medications are known to cause dizziness and drowsiness and can have potentiated side effects with an elderly individual, according to the patient's expert witness. **Heit v. Long Island Jewish Med. Ctr., __ N.Y.S.2d __, 2012 WL 3204526 (N.Y. App., August 8, 2012).**

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# Fall: Jury Awards Damages For Nursing Negligence.

The patient, who had been a paraplegic for more than twenty years, was admitted to the hospital for pneumonia.

The day after admission he wanted to take a shower. The patient's nurse could not locate a shower chair in the hospital so the patient was allowed to have someone bring in his shower chair from home. It had suction cups but no wheels.

A nurses aide placed the shower chair in the shower in the bathroom and allowed the patient to attempt by himself to transfer from his wheelchair to the shower chair.

The patient fell, struck his head on the toilet and wrenched his shoulder causing a rotator cuff injury.

In the patient's lawsuit against the hospital the county district court judge directed a verdict that the hospital was negligent and allowed the jury only to decide the amount of damages. The jury awarded $3,000,000+ which the judge reduced to $1,000,000, the maximum allowed in Nebraska in a lawsuit against a government-owned medical facility.

The Supreme Court of Nebraska ruled the judge was wrong not to let the jury decide if the hospital was negligent and ordered a new trial.

The Supreme Court did review in detail the testimony that was taken into consideration by the district court judge.

**Bathroom Too Small For Shower Chair, Wheelchair and Caregiver(s) Assisting the Patient**

The patient's lawsuit alleged a violation of the Americans With Disabilities Act by the hospital, that is, failure to provide reasonable accommodation for his disability, as well as negligence, for the simple fact the bathroom was too small.

The patient testified his wheelchair was only partially in the bathroom itself and still partially in the doorway when he attempted to transfer by himself.

The nurses aide who placed the shower chair in the shower testified that after placing the shower chair in the shower she was standing by with the intent of helping the patient if he needed help.

However, there was not enough room in the bathroom for her to go in and be present and actually assist the patient as he attempted the transfer by himself.

***The patient's nursing expert, a nursing instructor with a PhD, testified the hospital's nursing personnel committed violations of the standard of care.***

***They failed to have a reasonably safe environment for the patient, failed to comply with the Americans With Disabilities Act, failed to assess and monitor the patient properly and failed to assist in the transfer.***

SUPREME COURT OF NEBRASKA
August 3, 2012

**Hospital Policies for Patient Transfers**

A nurse from the hospital, who was not involved with the patient's care, testified it was hospital policy for a single caregiver working alone with a patient to call for help if there was any doubt whatsoever whether the patient could be transferred safely.

The nurse testified the best practice to insure the patient's safety would have been to have transferred the patient to a wheeled shower chair in the hospital room where there was plenty of open space.

Two persons and a gait belt and possibly a mechanical lift could and should have been used to move the patient.

Then after he was safely and securely in the shower chair he could be wheeled into the shower, take his shower, be wheeled back into the hospital room and the transfer process repeated in reverse.

**No Fall Risk Assessment**

The nurse also testified it was hospital policy for all patients upon admission to have a fall risk assessment. There was nothing in the chart indicating that a fall risk assessment was ever done by the nurses with this patient.

Based on his paraplegia alone, the nurse testified, this patient would have been considered a high fall risk. **Green v. Box Butte Gen. Hosp., 284 Neb. 243, __ N.W. 2d __, 2012 WL 3137990 (Neb., August 3, 2012).**

# Fall: Court Allows Patient's Case To Go Forward.

The fifty-three year-old patient was 5' 3" tall and weighed 200 lbs.

Her medical diagnoses included the brain disorder leukodystrophy, dementia, seizures and significant osteoporosis.

She was in the nursing facility for physical rehabilitation with the goal of restoring independent ambulation with a walker. She was a high fall risk, according to her admission nursing assessment, and her care plan expressly called for two persons to assist her with transfers.

When her daughter came to visit she found her mother sitting on the toilet in her bathroom. She had her mother pull the string to call for help. The aide who responded told the daughter the aide assigned to the patient had gone to lunch.

The aide tried to transfer the patient to her wheelchair. The patient landed on the floor with her leg twisted in front of her. The aide got another person and the two of them finally got her into her wheelchair.

***An orthopedic expert is not required to prove that the patient's tibia and fibula fractures were caused by the fall and were not pathological fractures related to her osteoporosis.***

APPEALS COURT OF MASSACHUSETTS
July 26, 2012

The Appeals Court of Massachusetts stated that the aide deviated from the applicable standard of care in three ways:

Trying to do the transfer alone when two aides were required by the care plan;

Failing to use a gait belt; and

Failing to lock the wheels of the wheelchair.

The Court ruled the lower court judge erred directing a verdict in favor of the facility. The patient did not call an orthopedist to testify as an expert but she did not need an expert to prove the fall caused her tibia and fibula fractures. **Pitts v. Wingate, 82 Mass. App. Ct. 285, __ N.E. 2d __, 2012 WL 3023983 (Mass. App., July 26, 2012).**

## Arbitration: Resident Is Presumed To Have Been Competent.

The employee who helped the nursing home resident sign the admission papers testified it was standard practice to explain the entire admission agreement, including the arbitration clause, and make sure the resident understood everything.

If there was any doubt about the resident's ability to understand what he or she was signing, the process was to be turned over to a physician or nurse to assess the resident's mental competency to understand and sign legal documents.

If the resident seemed confused, inquiry would be made to see if someone held a power of attorney for the resident's affairs, and the resident would not be asked to sign anything.

The District Court of Appeal of Florida pointed out that any adult is presumed to be competent to sign a valid contract.

The deceased patient's family, who wanted to get around the arbitration agreement and sue in court, had no evidence that Alzheimer's, delirium, delusions, confusion or psychiatric problems were present when she signed the admission paperwork. **John Knox Village v. Perry, __ So. 3d __, 2012 WL 3537057 (Fla. App., August 17, 2012).**

## PTSD + COPD: Court Says No Nursing Negligence Was Involved In Psychiatric Patient's Death.

The patient was a Vietnam veteran who was admitted to a Veterans Administration facility for treatment of post-traumatic stress disorder (PTSD).

The facility is a tertiary psychiatric facility which, unlike a typical hospital, has no emergency department and does not perform surgery. It does have an urgent care facility and a med/surg floor.

The patient was housed in a transitional care dormitory setting while undergoing care for PTSD.

**History of Chronic Obstructive Pulmonary Disease**

The patient's medical history included a diagnosis of chronic obstructive pulmonary disease (COPD) five years earlier.

In the five years preceding his admission to the psychiatric facility he had been seen numerous times in hospital emergency rooms for breathing problems.

**Events Leading to Patient's Death**

The patient began one morning to have difficulty breathing. A physician's assistant called a code. The patient was given a chest x-ray and taken to the facility's urgent care unit. After a couple of hours his condition seemed to improve and he was able to walk back to the dormitory unit under his own power.

Back in the unit where he was housed he was assessed by the nurses twice that afternoon over several hours time.

Both times his vital signs were found to be normal and he was told to report any changes in his condition.

The patient's nurse assigned a health technician to check on the patient at least once every hour. At 12:00 midnight the patient was in bed asleep and was breathing normally. At 1:00 a.m. he was awake in bed but was not experiencing any apparent difficulty breathing.

At 1:40 a.m. the resident in the next room heard the patient in distress and called the health tech. The health tech came to the patient's room, left the room to call a code, returned to the room and then left again to make the code call again.

The code team arrived within three minutes and found the patient unresponsive and cyanotic. The physician on the code team performed CPR which improved the patient's color and his pulse, but he never regained consciousness and died several months later.

**Court Finds No Negligence**

The US Court of Appeals for the Third Circuit affirmed the lower Federal Court's finding of no negligence.

There was no departure from the accepted standard of care in the way the nurses and the non-licensed staff assessed and monitored the patient.

Because the patient's condition had apparently resolved, there was no negligence involved in the decision to discharge the patient from urgent care back to his dormitory setting rather that keeping him in urgent care or transferring him to an outside acute care hospital facility. **Keating v. Coatesville VA Med. Ctr., 2012 WL 3140915 (3rd Cir., August 3, 2012).**


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# Sexual Harassment: Court Faults Employer's Response, Validates Nurse's Lawsuit.

Two months after a male nurse co-worker began making sexually inappropriate comments to a female staff nurse she phoned the nursing director.

The director had been involved in hiring the male nurse and knew from his employment references he had been fired for violation of his previous employer's sexual harassment policy.

His offensive conduct continued. Two weeks after the phone call the nursing director told the nurse/victim that after she got written statements she would investigate the situation. The nursing director promised to start sexual harassment training sessions. The director met with the perpetrator a few days after that and gave him a "final" warning. Still the nurse had to work on the same floor as he did for several more months and had to go to great lengths to avoid him. She went to a psychiatrist and was put on antidepressants.

Five months after the phone call to the nursing director the male nurse was fired for an off-campus romantic affair with a former patient.

**Court Validates Nurse's Lawsuit**

Occasional teasing, offhand comments, sporadic use of abusive language and gender-related jokes are an accepted fact in the workplace and do not amount to a sexually hostile work environment.

The US District Court for the Middle District of Pennsylvania ruled in this case that the nurse had valid grounds for a sexual harassment lawsuit.

The director of nursing did basically nothing for nineteen days after a complaint of harassment from a female staff nurse by a recently hired male staff nurse whose record from his former employer contained two charges of sexual harassment, one of which had led to his termination.

The two nurses were not separated, his widely known offensive conduct continued and nothing was done to stop him.

The allegations of harassment were supported by statements from other nurses and a nursing unit manager who investigated the first victim's allegations. **Lawrence v. Schuylkill Med. Ctr., 2012 WL 3536978 (M.D. Pa., August 14, 2012).**

***The focus is on the timing and the adequacy of the employer's response in sexual harassment cases involving co-workers on the same level in the institutional hierarchy.***

***Employees' lawsuits have been dismissed in cases where management undertook an investigation within a day after being notified of the harassment, spoke with the alleged harasser about the allegations and the employer's sexual harassment policy, warned the harasser that the inappropriate conduct would not be tolerated and acted upon that warning when necessary.***

***An employer can be liable to the victim in a sexual harassment lawsuit for the harassing conduct of a co-worker if the employer was negligent or reckless in failing to train, discipline, fire or take other effective remedial action upon notice that harassment was happening.***

***In this case basically nothing was even started for nineteen days after the first victim came forward and no investigation was undertaken until two days after two more victims spoke out. That was not right.***

UNITED STATES DISTRICT COURT
PENNSYLVANIA
August 14, 2012

# Abuse: Nurses Aide Fired For Misconduct.

At 3:00 a.m. a nursing assistant employed in a nursing home received two calls at almost the same time, one from one resident's call light and one from a floor alarm in another resident's room.

She answered the call light first, then went to the other room. There the resident had removed her gown and thrown it on the floor along with a pillow that apparently set off the alarm.

The resident asked the aide to untie the tight knot near the head opening at the top of the gown.

The aide, who was apparently miffed at having to answer both calls without any help from the others on duty, became angry with resident and tried to force the gown back over her head without untying the knot, yelling at the resident who did not have her hearing aid in, while the resident was crying out in protest.

***Abuse of a patient is grounds for terminating a patient-care worker.***

***Abuse is non-accidental conduct which produces or which reasonably could be expected to produce physical pain or injury or emotional distress.***

COURT OF APPEALS OF MINNESOTA
July 23, 2012

The Court of Appeals of Minnesota ruled the facility had grounds to terminate the nurses aide for aggravated employment misconduct.

The definition of employment misconduct for an employee of a nursing home or hospital or other patient-care facility includes an act of patient or resident abuse, financial exploitation or recurring or serious neglect.

The definition of abuse includes conduct which is not an accident which produces or could reasonably be expected to produce physical pain or injury or emotional distress. **Borg v. Regina Med. Ctr., 2012 WL 3023398 (Minn. App., July 23, 2012).**

## Diversion: Nurse's No-Contest Plea Does Not Stop Defamation Suit.

Nurse managers at a mental health and addiction center suspected a particular nurse was diverting Adderall XL by tampering with capsules in the medication room and removing granules of the drug.

One afternoon the nurse was put in charge of the med room and other nurses were told not to enter the med room during the p.m. shift. When Adderall XL capsules were found tampered with the nurse was fired for this and two prior incidents.

The nurse was terminated expressly for diversion of a controlled substance and was reported to the local police and to the state Board of Nursing.

***The nurse was denied unemployment benefits on the grounds of gross misconduct. He entered into a consent order with the Board of Nursing and pled no contest to criminal charges.***

***None of the above prevents him from suing his former employer for defamation.***

SUPREME COURT OF VERMONT
August 10, 2012

Without ruling one way or the other on the allegations raised in his defamation lawsuit against his former employer, the Supreme Court of Vermont ruled the nurse being turned down for unemployment, entering into a consent order with the Board of Nursing and pleading no contest to criminal charges did not prevent him from suing for defamation.

To defend itself in the defamation suit the facility will have to prove the truth of the reason given for his termination, that he did in fact three times divert a controlled substance, not just less inflammatory accusations of substandard documentation or medication errors. **Shaddy v. Brattleboro Retreat, __ A. 3d __, 2012 WL 3239280 (Vt., August 10, 2012).**

## Discrimination: Minority Nurse's Suit Dismissed.

A minority nurse was promoted from staff nurse to a supervisory clinical nurse position, with the stipulation that in her new job she would be on probationary status for a period of one year.

Two months into her probationary period her supervisor began to hear a good deal of negative feedback from the nurses she supervised. A chaplain at the facility was asked to conduct sensitivity sessions where the nurses were encouraged openly to voice their concerns about the nurse's leadership style.

The upshot was that the nurse's appointment to the supervisory clinical nurse position was terminated and she was demoted back to staff nurse status. The reason given to her was that her management skills and leadership style did not meet the facility's expectations.

***A Caucasian nurse who was not demoted over problems with his leadership style is not a valid basis of comparison because he was no longer on probationary status at the time concerns surfaced about his job performance.***

UNITED STATES DISTRICT COURT
KANSAS
August 9, 2012

The US District Court for the District Court of Kansas dismissed her discrimination lawsuit.

The basics of a discrimination case were present. She is a minority, she was subjected to adverse employment action she and was replaced by a non-minority.

However, according to the Court, the very purpose of serving a probationary period is to assess the newly appointed person's management skills and leadership style in the new position. These were lacking, in her supervisors' opinion, in that she consistently offended those beneath her with her rude personal attitude. **Gaskins v. Dept. of the Army. 2012 WL 3245455 (D. Kan., August 9, 2012).**

## Discrimination: Minority Nurse's Suit Will Go Forward.

A minority nurse's relationship with her supervisor was filled with tension caused by her impression that her Caucasian supervisor held a bias against her as an African-American from Nigeria, based in part on comments from her supervisor that another Nigerian was "dumb" and should be forced out of his position.

A nurse she supervised had a known drug problem. He got an order for himself from a physician at the facility for Phenergan, ostensibly because he was nauseous, had a non-licensed technician inject him and then fell asleep on duty. The next day the nurse had the technician inject him again, this time with no physician's order, and again he fell asleep. The nurse wrote him up, reported him to the Board of Nursing and then told her supervisor.

Friction over this episode and over complaints to her supervisor about staffing issues led to the nurse's termination.

***The nurse's supervisor criticized her for taking disciplinary action and reporting her subordinate to the Board of Nursing without asking her first.***

***This was a restriction the supervisor did not place on non-minority nurses and it is discriminatory.***

UNITED STATES DISTRICT COURT
MARYLAND
August 8, 2012

The US District Court for the District of Maryland ruled that the nurse had rights under the employment anti-discrimination provisions of the US Civil Rights Act, under the state's nurse practice act which unequivocally required her to report her subordinate's conduct and protects her from reprisals for doing so and under the whistleblower statute for her complaints about critical staffing issues. **Ezeh v. Bio-Medical Applications, 2012 WL 3263868 (D. Md., August 8, 2012).**

# Whistleblower: Court Refuses To Dismiss Nurse's Lawsuit.

A nurse discovered a smelly substance which she feared was black mold in a cabinet under the sink in the dialysis unit of the health facility of the correctional institution where she worked.

She talked to a number of individuals at the facility about what she discovered.

One of them, who had completed an eight-hour janitorial orientation but had never been trained to collect and analyze samples and identify mold, believed it was just a combination of dirt, rust and calcium from a leaking p-trap under the sink.

Further up the facility hierarchy, the assistant health services administrator, who had degrees in both chemistry and biology, also had the general impression, without any testing or analysis, that it was not mold. The nurse collected samples on sterile q-tips, but no one was interested.

She was then informed that the under-sink space had been thoroughly cleaned and bleached, but the suspicious odor returned shortly anyway.

A few days later the nurse observed a substance she believed was the same she had seen in the cabinet under the sink had spread to the baseboards in an adjacent treatment room.

Finally, after the deputy warden refused to listen to her complaints, the nurse contacted the local office of the Occupational Safety and Health Administration and informed her superiors that she had done so.

**Nurse Terminated for Her Complaints**

The nurse sued her former employer alleging she was terminated because her superiors considered her a "loud-mouth" and a "troublemaker" who was acting unprofessionally by creating tension over health and safety issues that could boil over into inmate complaints. She was also accused of going outside the chain of command with her complaints, which was also considered unprofessional conduct.

The US District Court for the Middle District of Tennessee ruled that the nurse fit the legal definition of a whistleblower who was entitled to protection from employer reprisals under state law and she had the right to sue over her termination. **Gore v. Chardonnay, 2012 WL 3552882 (M.D. Tenn., August 16, 2012).**

***The question is whether the nurse complained about an illegal activity.***

***An employee is protected by the state's whistleblower law from employer reprisals if the reprisals were the result of the employee refusing to participate in or to remain silent about illegal activity or activities by the employer in the workplace.***

***The courts have ruled that Joint Commission National Patient Safety goals are merely expressions of "aspirations" about patient safety. A complaint by a nurse that the Joint Commission's goals not being met is not a valid basis for a whistleblower case even if the nurse suffers consequences afterward.***

***However, in this case the nurse was able to cite a specific state Department of Health regulation which is intended to protect the public health and safety and which does apply directly to her work environment, a dialysis clinic, and which expressly says that the physical environment of the facility must be maintained in a safe, clean and sanitary manner.***

***The nurse has the right to sue her former employer over her termination.***

UNITED STATES DISTRICT COURT
TENNESSEE
August 16, 2012

# Home Health: Court Says Nurses Must Have Caused Patient's Injury.

The husband wanted to sue his late wife's home health agency alleging that her home health nurses negligently fractured her arm while caring for her.

The husband's lawyers, however, waited until after the statute of limitations had expired before they filed the lawsuit, so the lawsuit against the home health agency was dismissed. The husband then sued his lawyers for legal malpractice.

***The patient's E.R. records showed a fracture consistent with a twisting type injury to the right upper extremity with a concurrent axial loading likely caused by falling or being dropped on to her arm.***

***The quadriplegic total-care patient could not have caused the injury to herself.***

COURT OF APPEALS OF OHIO
August 14, 2012

The Court of Appeals of Ohio ruled that there was sufficient circumstantial evidence for a case of nursing negligence against the home health agency.

Therefore, although it was no longer possible to sue the home health agency, the husband did have a valid case of legal malpractice against the lawyers for allowing the statute of limitations to run out before filing what would have been a valid court case against the home health agency.

The Court ruled it was not relevant that one nurse from the agency cared for the patient from 7:00 a.m. to 4:00 p.m. and another nurse from the same agency, who first reported the fracture to the husband who called the ambulance, was on duty from 4:00 p.m. until 11:00 p.m. One or the other nurse was the only person who could possibly have caused the problem for this bedridden totally dependent quadriplegic patient. **Carter v. Vivyan, 2012 WL 3291824 (Ohio App., August 14, 2012).**

## HIPAA: Disclosure Of Protected Health Information By Employee Whistleblowers.

**Uses and disclosures of protected health information: general rules.**

(a) *Standard.* A covered entity may not use or disclose protected health information, except as permitted or required by this subpart ...

(1) *Permitted uses and disclosures.* A covered entity is permitted to use or disclose protected health information as follows:

(i) To the individual;

(ii) For treatment, payment, or health care operations ...

****

(iv) Pursuant to and in compliance with a valid authorization ...

****

(j) (1) *Disclosures by whistleblowers.* A covered entity is not considered to have violated the requirements ... if a member of its workforce or a business associate discloses protected health information, provided that:

(i) The workforce member or business associate believes in good faith that the covered entity has engaged in conduct that is unlawful or otherwise violates professional or clinical standards, or that the care, services or conditions provided by the covered entity potentially endangers one or more patients, workers or the public; and

(ii) The disclosure is to:

(A) A health oversight agency or public health authority authorized by law to investigate or otherwise oversee the relevant conduct or conditions of the covered entity or to an appropriate health care accreditation organization for the purpose of reporting the allegation of failure to meet professional standards or misconduct by the covered entity; or

(B) An attorney retained by or on behalf of the workforce member or business associate for the purpose of determining the legal options of the workforce member or business associate with regard to the conduct described in paragraph (j)(1)(i).

CODE OF FEDERAL REGULATIONS
Title 45 Section 164.502

# Patient Confidentiality: Nurse Cannot Use Patient Information In Her Whistleblower Lawsuit.

***The nurse will be barred from using her log or any of the confidential information in her log as evidence in her lawsuit against the hospital alleging she was terminated for legitimate whistleblowing activities.***

***The US Health Insurance Portability and Accountability Act contains limited exceptions to the ironclad rule of strict confidentiality which allow certain disclosures of confidential information by whistleblowers.***

***An employee can disclose information he or she has taken from a medical chart to a governmental agency or authority with the power to investigate the conduct or conditions at issue or to an appropriate healthcare accreditation organization.***

***Information taken by the employee from a chart can also be disclosed to the employee's attorney for the purpose of obtaining advice as to the employee's legal options as a whistleblower.***

***However, the HIPAA does not allow a healthcare employee to use confidential patient information in the employee's own lawsuit which the employee has taken from a patient's chart.***

UNITED STATES DISTRICT COURT
OHIO
July 27, 2012

An RN employed in a psychiatric hospital began having suspicions that the facility's medical director was involved in fraudulent and illegal activities. She began keeping a log of his allegedly suspicious activities which included specific patients' names, ages and room numbers.

She took her log home with her, photocopied it and sent the photocopy to a state Department of Health investigator. The investigator decided the Department would not pursue a case against the medical director. The nurse also gave a copy of her log to her own attorney.

**Nurse Terminated for Violation of Patient Confidentiality**

The nurse was terminated for contacting and meeting a patient's family at an off-site location, considered improper fraternization with a family member, and for improperly removing confidential information from patients' charts.

**Nurse Barred From Using Confidential Information in Her Own Lawsuit**

The US District Court for the Southern District of Ohio pointed out that a healthcare employee is allowed to remove confidential patient information from a patient's chart to disclose it to a health oversight agency authorized by law to investigate the relevant conduct or conditions at the facility or to an appropriate healthcare accreditation organization.

A healthcare employee can also provide confidential patient information to his or her own attorney to obtain advice as to the employee's legal options.

A healthcare employee, however, is not allowed to use confidential information the employee has taken from a chart such as photocopies of medical records or even the patient's name or other confidential data copied by hand from a chart as evidence in a whistleblower lawsuit or other legal proceeding.

To be able use such information in court the employee or a lawyer must obtain it through the court's civil discovery processes which have "de-identification" procedures built in to protect patients' privacy.

**Cabotage v. Ohio Hosp. for Psych., 2012 WL 3064116 (S.D. Ohio, July 27, 2012).**

LEGAL EAGLE EYE NEWSLETTER
*For the Nursing Profession*

## Correctional Nursing: Nurses Did Not Follow Protocols.

In response to a Federal investigation of conditions in the jail the county adopted a number of standing protocols to guide the nursing staff in assessing and treating inmates' medical complaints. One of the protocols dealt specifically with diabetic inmate patients.

An inmate who did not know he was diabetic and had not reported it during his intake exam came to the dispensary with vomiting and abdominal pain. He was given Phenergan and sent back to his cell. He was reportedly given a bucket to take to his cell because he continued vomiting and had to urinate twenty times a day.

Finally a physician was called in who would later testify that he displayed symptoms of dehydration the nurses should have recognized. That afternoon his blood sugar was so high it could not be measured and he was taken to the hospital where he had to have a leg amputated.

The Court of Appeals of Kentucky saw grounds for a lawsuit against the jail nurses for failing to follow the jail's set protocols. **Osborne v. Aull, 2012 WL 3538276 (Ky. App., August 17, 2012).**

## Medical Battery: Jury Turns Down Patient's Lawsuit.

At twenty-seven weeks a pregnant woman was told on the phone by her ob/gyn to go to the hospital after she fell down stairs at home.

A hospital labor and delivery nurse notified the obstetric resident that the fetal heart rate was too low. The resident consulted another obstetric resident and the mother's ob/gyn who agreed that an emergency cesarean was indicated.

The mother, herself a pediatric cardiology anesthesiologist, sued for medical battery after the obstetric resident successfully delivered the baby by cesarean, based on her belief that it was a only a benign arrhythmia in the fetal heart rate which did not call for a cesarean.

The Supreme Court of Pennsylvania agreed with the mother that even if it was a true obstetric emergency she still had the right to refuse to consent to a cesarean and if she refused the physicians and other personnel would be liable for medical battery for going ahead. However, the jury believed the resident's testimony that the mother did actually consent verbally. **Cooper v. Lankenau Hosp., __ A. 3d __, 2012 WL 3568786 (Pa., August 20, 2012).**

## Fall: Court Sees No Negligence In Patient's Care, Dismisses Lawsuit Against Nursing Home.

The resident, an elderly woman in her eighties, passed away in the hospital after she fell in the nursing home where she resided.

The medical review panel convened to review the evidence behind the family's lawsuit issued an opinion that the nursing home was not negligent.

The Court of Appeals of Indiana agreed that the evidence supported the panel's conclusions and dismissed the lawsuit.

The resident had urinary frequency and had to be toileted quite often and was also incontinent at times.

It was documented that she would regularly turn on her call light to obtain assistance in getting to the restroom and at times would try to make it to the restroom on her own rather than wait for assistance to arrive.

***Merely because an elderly person falls and injures herself in a nursing home, even when it has happened before, does not establish that it was the nursing home's responsibility to protect her from such a fall.***

***There was no proof of inadequate staffing or failure to respond timely to the alarms or that other measures that were realistic to expect would have prevented her from falling.***

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A bed alarm was provided, but then she started setting off her bed alarm to obtain assistance. She began having to get up to urinate every twenty to thirty minutes during the night and sometimes staff who responded to the bed alarm would find her on the floor.

One night when a staff person responded to her alarm they found her on the floor with a two-centimeter laceration on her forehead. She was taken to an emergency room within minutes where the physicians discovered a fractured wrist and spinal fractures. Although she was considered medically stable she passed away the next day.

According to the Court, the medical evidence did not show that any negligence by the nursing home caused her death. **Curts v. Miller's Health, __ N.E. 2d __, 2012 WL 3332408 (Ind. App., August 15, 2012).**