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LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

March 2013 Volume 21 Number 3

Informed Consent: Nurses Got Go-Ahead But Did Not Explain Risks, Benefits, Alternatives.

Fluid began to accumulate around the patient's lungs several days after open heart surgery.

The pulmonologist ordered a chest tube to drain the fluid and expected the interventional radiologist who was going to put the in tube to take care of obtaining informed consent.

Instead, two nurses phoned the patient's daughter and asked her to give consent for placement of the chest tube.

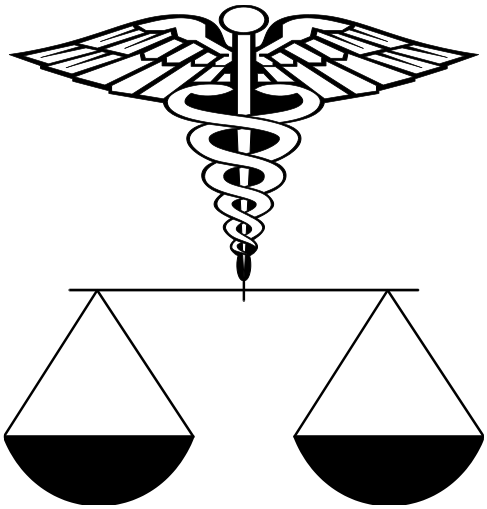
The patient herself was unable to consent due to advanced dementia and the daughter had earlier been named in the patient's durable power of attorney.

Nurses Did Not Explain Risks, Benefits, Alternatives

The nurses did not explain to the patient's daughter any of the risks, benefits or alternatives.

The nurses simply assured the daughter that, "It's no big deal," got the go-ahead from her, filled out a telephonic-consent form and inserted the form into the medical chart.

The next day the interventional radiologist, who was an independent contractor and not a hospital employee, went ahead with the procedure without discussing it with the patient, without checking to see if anyone had discussed it with the family and without attempting to contact the family, saying later on that it was an emergency.



The nurses phoned the patient's daughter and asked her to consent to the procedure on her mother's behalf.

However, the nurses never explained any of the risks, benefits or alternatives.

There may be grounds for a lawsuit over a bad outcome if the patient or family member was not given the opportunity for truly informed consent.

CALIFORNIA COURT OF APPEAL
January 30, 2013

During the procedure the guide wire punctured the aorta. That did necessitate emergency surgery to repair damage to the aorta, lung tissue and the pulmonary vein.

The patient's condition deteriorated steadily. She passed away eighteen months later after a downward spiral which was started by the physiologic stress from the aortic repair.

Hospital Did Not Obtain Informed Consent

The California Court of Appeal viewed the failure by the hospital's nurses to obtain informed consent as grounds for a lawsuit.

Failure to obtain truly informed consent can be the basis of a lawsuit, if the patient or patient's family can prove that they or a reasonable person in their shoes would have declined to consent to the procedure if they were told the potential risks involved.

The unfortunate outcome that actually came about was one of the salient risks of the procedure that should have been explained to the daughter, but was not, so that she could have made a truly informed decision whether to agree or to decline to consent on her mother's behalf, based on being intelligently informed of what could happen. **Gonsalves v. Sharp, 2013 WL 342668 (Cal. App., January 30, 2013).**

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March 2013

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High Fall Risk: Bed Alarm Not Turned On, Court Finds Grounds For Lawsuit Against Hospital.

The eighty-six year-old patient was admitted to the hospital after she fell at home.

The hospital used a fall-risk assessment tool developed at Johns Hopkins Hospital. The patient's score was twenty-two. Any score higher than ten was considered high risk.

As a high-fall-risk the patient was supposed to be placed and she was placed in a bed with an alarm that sounds when the patient moves, to alert staff that the patient may be attempting to climb out of bed.

Because the bed alarm sounds with movement, an employee attending to the patient must turn it off before moving the patient in bed and must reset the alarm before leaving the room.

One of the hospital's nurses acknowledged in her testimony in a pre-trial deposition that making sure the alarm is activated on leaving the room of a high-fall-risk patient is absolutely important, one of the nursing "ABCs."

The night-shift personnel came on duty at 7:00 p.m. The patient was noted to be sitting in her chair then and was charted being put to bed at 8:30 p.m. The night nurse charted checking on her at 11:41 p.m. and again at 4:00 a.m. A nursing assistant charted vital signs that evening.

At 5:30 a.m. the patient cried out for help and was found on the floor next to her bed. She was injured. The bed rails were up. The bed alarm had not sounded.

The hospital's investigation revealed that the alarm was not turned on at the time the patient was found. The alarm was not broken, it worked properly.

No One Other than Hospital Employees Were in the Room During the Early Morning Hours

Even though the nurse and the aides who were working that night testified they recalled resetting the alarm when they left the room, the Superior Court of New Jersey, Appellate Division, ruled that there was no explanation for the patient ending up on the floor injured with the bed alarm turned off other than a hospital employee neglecting to turn the alarm back on after attending to the patient in bed.

The preventive interventions that were necessary for this high-fall-risk patient were proven in court by the very testimony of the hospital nursing personnel on duty that night.

The only probable explanation is that one or more of the hospital's employees failed to carry out their duty, that is, failed to see that the bed alarm was activated for this patient.

SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
January 30, 2013

We reported a prior ruling in this case in November, 2011: *Patient Fall: Nurse Did Not Turn Bed Alarm Back On.,* Legal Eagle Eye Newsletter for the Nursing Profession, (19)11, Nov., 2011 p.7.

The Court at that time refused to allow the patient's attorneys to add the nurse and aides as defendants in the case who cared for the patient that night, their names only having been learned after the chart was obtained by the patient's attorneys after filing suit against the hospital itself.

The statute of limitations expired before the attempt was made to add the nurse and the aides as defendants in the lawsuit, the Court ruled.

This time the Court ruled that the identity of the individual who actually left the alarm turned off was immaterial to the patient being able to go forward with a lawsuit against the hospital.

Just as there was no reasonable explanation for how it happened other than the bed alarm having been left turned off, there was no reason to doubt that it was a hospital employee who was responsible, no one else having gone into the room that night. **Ruday v. Shore Mem. Hosp., 2013 WL 331492 (N.J. Super., January 30, 2013).**

Documentation: Nursing Note Almost Sinks Hospital's Case.

The fifty-eight year-old patient was being treated in a VA hospital for complications of a diaphragmatic hernia sustained decades earlier as a result of combat trauma in the Vietnam War.

His physicians were watching him for signs of an adynamic ileus. Unlike the ileus that is not uncommon in post-surgical patients, digestive function does not return after a normal recovery period and distention and rupture of the stomach and intestines can lead to tissue death, vomiting, aspiration and cardiopulmonary stress in a patient with pre-existing cardiac problems.

A surgical resident ordered a clear liquid diet to be advanced as tolerated to full liquids, then to a regular cardiac diet.

The patient died from cardiac arrest secondary to gastric and colonic eventration through a left diaphragmatic hiatus secondary to right colon abdominal ileus.

The widow's lawsuit was based on a nursing progress note that appeared to state that the patient had eaten solid food which would have been highly inappropriate for him at the time the note was written.

A nurse charted that the patient had eaten 60% of his diet and 200 cc's of clear liquids.

UNITED STATES COURT OF APPEALS
FIRST CIRCUIT
February 12, 2013

However, the VA Hospital's experts were able to convince the judge that the ambiguous nursing note about the patient having "eaten" really only meant that he had consumed a portion of the liquid meal that the dietary records showed had been appropriately ordered for him.

No damages were awarded. The lower Federal court judge's interpretation of the nursing documentation, favorable to the VA Hospital, was not overruled by the US Court of Appeals for the First Circuit (Massachusetts). **Jackson v. US, __ F. 3d __, 2013 WL 500857 (1st Cir., February 12, 2013).**

Skilled Nursing Admission: Family Member Had No Authority To Agree To Arbitration.

The elderly patient was transferred on four separate occasions from the hospital to a skilled nursing facility.

Each time the paperwork was completed outside the patient's presence by a certain family member and representatives of the facility. Each set of papers included an arbitration agreement.

After he died the family sued the facility. The Court of Appeals of Kentucky ruled against the nursing home's insistence that the case go into arbitration rather than jury trial in the local county court.

Durable Power of Attorney

The patient's durable power of attorney actually named as his attorney-in-fact the family member who signed for him.

However, a durable power of attorney only confers authority on the named individual to enter into binding contracts on the patient's behalf after the patient has become no longer capable of making his or her own decisions. There was no evidence this patient had yet reached that stage, so the power of attorney was not yet effective. **Kindred Hosp. v. Clark, 2013 WL 593883 (Ky. App., February 15, 2013).**

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Dehydration, Sepsis: Court Sees Grounds For Family's Lawsuit.

To monitor a patient properly for dehydration there must be adequate measurement of fluid intake and urinary output.

However, there was no quantitative record in the chart of this patient's fluid intake or urine output.

The nursing home staff knew or should have known that this patient had many risk factors for dehydration.

Dehydration poses a risk of urinary tract infection and further risk of sepsis.

There was no documentation of the deterioration of the patient's condition which resulted in her hospitalization near death, or that the family or the physician were notified of her change in status.

Lack of documentation points to an overall failure to care for the patient competently.

COURT OF APPEALS OF TEXAS
December 14, 2012

After only five days in the nursing home the patient had to be sent to the hospital, where almost three liters of fluid was drained from her bladder via a urinary catheter.

She died the next day from cardiopulmonary failure due to septic shock from a urinary tract infection.

The family's medical expert was highly critical of the care she had received in the nursing home. The Court of Appeals of Texas ruled that the family's expert's report stated valid grounds for a lawsuit.

The initial assessment failed to mention her significant cardiac history and advanced renal disease. Renal insufficiency placed her at high risk for dehydration. Advanced age and dementia were other risk factors for dehydration.

A patient with these risk factors for dehydration needs to be offered and encouraged to take fluids.

The facility must record clinical information in the chart to show that the patient's condition is being monitored.

Absent was any documentation of fluid intake and urinary elimination.

There was no documentation of the deterioration of the patient's condition for several days before she had to be transferred to the hospital, or that the family or physician were notified of her change in health status.

Dehydration can contribute to a urinary tract infection which can lead to sepsis, septic shock and death in a frail elderly person, as the family's expert stated in this case. **MSHC v. Miller, __ S.W. 3d __, 2012 WL 6218001 (Tex. App., December 14, 2012).**

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Fall: Nurse's Fraudulent Concealment Of The Facts Extends Statute Of Limitations.

The elderly nursing home patient was taken to the hospital when she started vomiting a few hours after she sustained a head injury.

Her head injury led to her death in the hospital nine days later.

When she was hospitalized a nurse from the nursing home told the family that the patient had had sudden transient ischemic attacks in the past which could not be anticipated or prevented and that such an event was most likely what caused her to fall this time.

Family Learned the Truth Almost Three Years Later

However, almost three years after the death a former employee of the nursing home told the daughter that her mother did not simply fall, but was attacked and pushed to the floor by another resident.

An attack by another resident, unlike the story the nurse from the nursing home gave to the family, could be grounds for a lawsuit alleging negligent failure to assess, monitor, supervise, restrain, transfer or separate the aggressor from other residents.

The family filed a negligence lawsuit against the nursing home, but filed it well beyond Indiana's two-year statute of limitations. The Court of Appeals of Indiana ruled that the family's lawsuit could go forward nevertheless.

Fraudulent Concealment Extends Statute of Limitations

The Court ruled that fraudulent concealment by a healthcare provider of facts from the patient or from the family, facts which could be the basis of a malpractice lawsuit, extends the statute of limitations.

The statute of limitations begins ticking not when the negligence occurs, but when the patient or the family who have been misled learn or with due diligence should have learned the true version of what happened.

The Court allowed the family's lawsuit because it was filed within two years of when the former employee told the daughter that her mother actually was pushed down by another resident. **Allredge v. Good Samaritan Home, __ N.E. 2d __, 2013 WL 372651 (Ind. App., January 31, 2013).**

The nurse's fraudulent concealment from the family of the true version of how their loved one was killed will extend the statute of limitations.

The family must file suit not within two years after the resident was injured but two years from the date a former nursing home employee told them what really happened.

Under the circumstances it would be wrong to deny the family the right to forward with a lawsuit on the grounds that the statute of limitations expired before they filed it in court.

The nursing home should not be allowed to take advantage of the fact that the true version of what happened was concealed from the family until after the statute of limitations ostensibly had passed.

Assuming they file their lawsuit within the extended time frame allowed, they will get their day in court, where the family still has to prove, as in any other professional negligence lawsuit, that the patient's death was caused by a negligent error or omission by the nursing home's care-giving staff.

COURT OF APPEALS OF INDIANA
January 31, 2013

Abuse: Charge Nurse Did Not Follow Procedure, Discrimination Case Dismissed.

The RN charge nurse was the only African-American nurse at the skilled nursing facility.

One Friday evening she saw a male Caucasian CNA grab the arm of an elderly female resident and yell at her to pick up a cup she had dropped on the floor.

The RN finished a tube feeding that was in progress. Then she phoned the DON who told her to send the CNA home immediately, so she told him to leave.

When she came in Monday morning the RN charge nurse wrote an account of the incident. She refused to speak further with a nurse sent from corporate to investigate. She was suspended and fired.

Facility policy required the charge nurse immediately to escort the abuser from the premises and then immediately to begin documenting eyewitness statements.

UNITED STATES DISTRICT COURT
MISSISSIPPI
February 7, 2013

The US District Court for the Northern District of Mississippi dismissed the lawsuit alleging race and age discrimination.

She was a minority, she was fired and she was replaced by a non-minority.

However, there was a legitimate, non-discriminatory reason behind her termination, the Court ruled, her failure to follow the facility's strict policies and procedures for responding to resident abuse.

The RN charge nurse should have escorted the abuser from the premises. She simply told him to leave and could not account for what he did before leaving or whether he actually left. Obtaining fresh eyewitness statements was also a crucial aspect of the facility's procedures, which she ignored. **Barrentine v. River Place, 2013 WL 494074 (N.D. Miss., February 7, 2013).**

Discrimination: Nurse's Case Is Turned Down.

An African-American RN complained to her supervisor that a co-worker had made a racially tinged remark that she considered offensive.

The supervisor immediately met with the co-worker to straighten her out.

When the co-worker made another comment two months later that offended the RN, she again reported it to her supervisor and her supervisor had another coaching session with the co-worker.

On another occasion the same co-worker said something disparaging about Mexicans, Asians and Jews, but the RN did not report that to her supervisor.

The RN herself was written up for work performance issues, but after she protested, the unfavorable write-up was removed from her personnel file.

Then she applied for a nursing position in another department that was considered a promotion and included a pay raise, and she got the position.

A racially hostile work environment is permeated with discriminatory intimidation, ridicule and insult.

UNITED STATES DISTRICT COURT
NORTH CAROLINA
February 4, 2013

The US District Court for the Middle District of North Carolina dismissed the RN's suit. There was insufficient evidence of a racially hostile work environment.

One co-worker made three comments which mentioned race. None of them were directed as insults at the RN herself. Nor were any of them physically threatening. One of the comments disparaged racial and ethnic groups to which she did not belong.

The RN's supervisor took prompt and appropriate remedial action which validated the RN's complaints.

There was no evidence that the RN's disciplinary history or available range of job opportunities was in any way impacted by racial bias. **Henley v. Movant Health, 2013 WL 424695 (M.D.N.C., February 4, 2013).**

Disability Discrimination: Direct Care Is An Essential Function Of A Charge Nurse's Position.

The charge nurse asked to be permanently excused from direct care responsibilities such as lifting patients, pushing wheelchairs or stretchers, responding to emergencies or anything that required her to be on her feet for twenty to thirty minutes at a time.

The hospital argued correctly that direct patient care in a large metropolitan hospital means that any nurse on duty must be able to attend to the needs of patients at all times, to move and transport patients and to respond to medical emergencies like assisting a patient who may have collapsed to the floor.

Consequently, the hospital's job description for a charge nurse defines the fundamental responsibilities as supervision and coordination of direct patient care by other nurses, but still defines direct patient care by the charge nurse as an essential function of the charge nurse's position.

The court is required to defer to the employer's judgment as to what are essential versus marginal functions in an employee's job description.

UNITED STATES COURT OF APPEALS
SECOND CIRCUIT
January 25, 2013

An RN charge nurse in a large metropolitan hospital sued her employer for disability discrimination because the hospital refused to excuse her permanently from all direct patient-care responsibilities.

Specifically she was denied an exemption from tasks that required physical effort like lifting patients, pushing stretchers and wheelchairs or standing on her feet for more than twenty minutes while attending to a patient's needs.

Her lawsuit pointed to Federal regulations interpreting the Americans With Disabilities Act which distinguish in general terms between so-called "essential" and "marginal" responsibilities of an employee's job description.

Qualified Individual With a Disability

A qualified individual with a disability, to benefit from the anti-discrimination laws, must be able, with our without reasonable accommodation, to perform the essential functions of the job.

The inability to perform marginal functions of the position, on the other hand, still permits the disabled individual to be considered qualified.

She claimed that her only essential function as a charge nurse was to supervise and coordinate the activities of other nurses, while direct patient care was only a marginal function for a charge nurse.

The US Court of Appeals for the Second Circuit (New York) dismissed the case.

Employer's Judgment
Essential vs. Marginal Job Functions

The courts as a rule are required to defer to the employer's judgment as to which functions are essential versus marginal in an employee's job description.

A charge nurse, according to this hospital's job description, in addition to being able to supervise others, must be able to provide direct patient care whenever necessary, and direct patient care is an essential function in the employer's judgment.

Direct patient care in a large metropolitan hospital requires a nurse staff nurse or a charge nurse to be able to attend to the needs of patients. **Davis v. NY City Health, 2013 WL 276076 (2nd Cir., January 25, 2013).**

EMTALA: Patient Had No Actual Proof Of Unequal Treatment.

The patient came to the hospital by ambulance after she began suffering from a right-side headache, slurred speech and numbness and weakness in her left-side extremities. The paramedics' records referred to stroke symptoms.

The patient was seen and released. She went to a different E.R. the next day and was transferred from there to a third hospital's neurological service for treatment of a massive stroke.

The hospital filed affidavits in court from the E.R. physician and the E.R. nurse that the patient was provided the same appropriate emergency medical screening examination that would have been given to any other patient in a similar condition with similar symptoms.

The patient was only able to allege there was disparity in her treatment, with no actual supporting evidence.

UNITED STATES DISTRICT COURT
LOUISIANA
February 5, 2013

The US District Court for the Western District of Louisiana dismissed the patient's lawsuit which alleged violation of the US Emergency Medical Treatment and Active Labor Act (EMTALA).

The EMTALA requires a hospital emergency department to give every patient the same emergency medical screening that any other patient would receive with similar signs and symptoms.

Although the Court had qualms about her assessment and care, the patient gave the Court no actual evidence to work with that proved she was treated differently than other patients. **Mays v. Bracey, 2013 WL 450156 (W.D. La., February 5, 2013).**

Emergency Room: Nurse Did Not Fail To Advocate For The Patient.

The patient was brought to the E.R. by paramedics at 11:45 p.m. with life-threatening gunshot wounds.

The E.R. physician phoned the on-call vascular surgeon. The vascular surgeon's arrival was delayed and the patient did not go into surgery until 2:45 a.m. He died in surgery at 7:00 a.m.

The E.R. nurse repeatedly checked with the E.R. physician and satisfied herself that the E.R. physician was continuing to make phone calls to get the on-call vascular surgeon to come in.

CALIFORNIA COURT OF APPEAL
February 6, 2013

The California Court of Appeal noted for the record that a malpractice lawsuit against the E.R. physician was dismissed as unfounded. This lawsuit against the nursing agency, the E.R. nurse's employer, met the same fate.

E.R. Nurse as Patient Advocate

The Court accepted the testimony of a nursing expert that the E.R. nurse's direct care was appropriate. She continually monitored her patient and fully appreciated the life-threatening nature of his injuries and the need for quick action.

Further, the E.R. nurse fulfilled her legal duty to advocate for her patient by repeatedly checking with the E.R. physician to make sure that he was continuing to make calls to get the on-call vascular surgeon to come to the hospital.

The only trauma surgeon duty at the hospital that night was operating on another gunshot victim at the time.

The Court dismissed the family's nursing expert's opinion that the E.R. nurse was required to go up the hospital's chain of command or to try herself to get a vascular surgeon to come in. **Ramirez v. On Assignment, 2013 WL 443423 (Cal. App., February 6, 2013).**

Discrimination: Court Finds No Valid Basis For Comparison.

A registered nurse was a racial minority and also had been diagnosed with neuropathy and tarsal tunnel syndrome which affected the range of nursing positions she could fulfill.

She was terminated from her employment at the hospital after a long series of disciplinary write-ups for job performance issues. After her termination she sued her former employer for race and disability discrimination.

To prove discriminatory discipline a minority or disabled employee must prove that at least one non-minority or non-disabled person was treated less harshly for the same or nearly identical misconduct.

UNITED STATES DISTRICT COURT
GEORGIA
February 8, 2013

The US District Court for the Middle District of Georgia dismissed her case.

To prove discriminatory employment discipline, a minority or disabled employee must prove that he or she was treated more harshly than at least one non-minority or non-disabled employee whose misconduct was nearly identical in all respects.

Employer's Meticulous Documentation

It is not enough for a victim who claims discrimination to identify a non-minority or non-disabled employee who in general terms also has an attitude problem or attendance or performance issues.

The hospital had so meticulously documented the details of this nurse's and the disciplinary histories of five non-minority, non-disabled nurses disciplined less harshly whom she held up for comparison that it was impossible for the court to see how they were similar enough to support a charge of discrimination. **Jest v. Archbold Med. Ctr., 2013 WL 503071 (M.D. Ga., February 8, 2013).**

Nursing License: Experts Must Define The Standard Of Care.

After the alarm sounded several times a nurse in the neonatal intensive care unit turned off the alarm on one of the infant's cardiac monitor, but rotated the screen so she could see it and remained close nearby.

While the alarm was off the parents who were staying with the infant saw the heart rate drop several times and notified the nurse. That led to a complaint to the hospital which led to a complaint by the hospital to the State Board which resulted in the nurse's license being revoked.

The hospital's written internal protocol was that the alarm could only be turned off while directly caring for the infant, taking vitals or bathing. The actual practice had been to permit the alarm to be turned off briefly if the nurse stayed close by, but an email had gone out saying that that practice was no longer to be tolerated.

The hospital's internal nursing protocols do not define the standard of care for purposes revoking a nurse's license.

Expert testimony is necessary.

MISSOURI COURT OF APPEALS
January 8, 2013

The Missouri Court of Appeals ruled that the State Board violated the nurse's rights by revoking her license.

There was considerable confusion about what exactly was the hospital's protocol for this situation.

The State Board has authority only to revoke a nurse's license for incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of professional duties. The hospital's internal protocols do not define the legal standard of care for a nurse. That has to be established by testimony from outside independent experts. **Luscombe v. Missouri State Board, __ S.W. 3d __, 2013 WL 68899 (Mo. App., January 8, 2013).**

Sexual Harassment By Patient: Court Dismisses Nurse's Case.

The employer's response to the nurse's complaint was reasonable and adequate.

The nurse filed an adverse incident report stating that she had been sexually harassed by a patient the first time she cared for him and again two days later.

The nurse's clinical manager did not interview her. She went forward on the assumption it was true.

The nurse's clinic manager met with the patient when he came in a few days later and told him he had to sign a behavioral contract to continue his dialysis treatments at the clinic.

He agreed he could be discharged or transferred if there was any more inappropriate behavior.

The clinic manager told the charge nurse not to assign the nurse to this patient and saw to it that those who scheduled his appointments knew not to schedule him when the nurse would be in the facility. Their presence in the clinic did sometimes overlap by half an hour.

There has to be a balance struck between the employee's rights and the patient's right to receive treatment.

UNITED STATES DISTRICT COURT
HAWAII
February 11, 2013

A nurse working in a dialysis clinic complained to her supervisor and later filed a lawsuit over sexual harassment by a male dialysis patient.

The patient reportedly made several lewd and suggestive comments during the initial interview and then touched the side of her breast and her back during the first dialysis treatment and then continued with the verbal acting out when he came in for his next dialysis session two days later.

Clinic's Response Was Prompt and Appropriate

The US District Court for the District of Hawaii dismissed the lawsuit because the clinic met its legal responsibilities.

The Court said that the facility's legal responsibilities began as soon as the nurse made her superiors made aware of the situation through the incident report she handed in after the second episode.

The Court accepted the charge nurse's testimony that if she had been informed sooner, right after the first session with the patient, she would not have assigned the nurse to care for him again.

The clinic manager, as soon as she got the incident report, met the patient and required him to sign a behavioral contract acknowledging he would be discharged if he acted out again.

The manager felt she did not need to take the usual first step of interviewing the victim, as the manager fully accepted as true what was in the incident report.

The nurse was never assigned care for the patient again and an effort was made to schedule him to minimize as much as practicable him and the nurse even being in the building at the same time.

Patient's Needs Must Be Taken Into Consideration

The Court pointed out that there were very limited options in the specific locality for places the patient could go to receive his needed dialysis treatments.

Even when a patient has acted out inappropriately, the patient's own needs have to be taken into consideration in fashioning a remedy to protect the patient's caregivers from possible further inappropriate contacts, the Court said. **Mariano v. Liberty Dialysis, 2013 WL 560893 (D. Hawaii, February 11, 2013).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Narcotics Diversion: Court Says DON Can Be Liable For Nurse's Family Member's Murder.

The civil lawsuit was filed by an adult son alleging that his father was murdered by the father's wife. The lawsuit alleged he was killed by administration of lethal doses of drugs, including po morphine, which the father's wife diverted from her employment as a nurse at a nursing home.

At this stage the US District Court for the Western District of Kentucky has only put aside a legal technicality and has not yet reached the ultimate issue of liability.

The lawsuit was filed against the corporation which owns the nursing home and against the nursing home's director of nursing.

The corporation is not a citizen of Kentucky. As an out-of-state corporation, if it were the only legitimate defendant, it would have the right to remove the lawsuit from Taylor County, Kentucky, Circuit Court to the Federal District Court for the Western District of Kentucky.

However, the nursing home's DON is a citizen of Kentucky. Since the lawsuit alleges valid grounds against her as a legitimate co-defendant along with the corporation, the family is entitled to its day in court before a hometown jury in Taylor County against both defendants.

Illicit Use of Narcotics
Foreseeable Consequence of Diversion

A healthcare facility's director of nursing has a legal duty to implement protocols and supervise the storage, maintenance and destruction of controlled medications used at the facility.

Breach of that legal duty can be the basis of a civil negligence suit by or on behalf of a person who was harmed as a foreseeable result.

To be considered foreseeable it is not necessary to be able forecast the specific event that occurred. It is sufficient if some injury to some person can be anticipated to result from a breach of the healthcare professional's legal duty.

It came to light through an internal audit at the facility that there were major discrepancies in the storage and wasting of controlled substances, including morphine.

For the family to get a jury verdict in their favor they still have to make their case to the jury by bringing in experts to show the standard of care as defined by State regulations, to prove that those standards were violated and to convince the jury that violation of those standards caused the man's death. **Wise v. Extendicare, 2013 WL 495408 (W.D. Ky., February 7, 2013).**

Narcotics Diversion: Court Sees Grounds For Nurse's Termination For Employee Misconduct.

An LPN was fired after an investigation that was started after a routine audit of controlled substances.

The investigation revealed that the nurse failed to account for medications on six occasions.

The nurse withdrew a 5 mg dose of methadone and failed to document whether it was given to the patient, returned or wasted.

She removed 10 mg of oxycodone and failed to account for it.

She removed two 5 mg doses of oxycodone and documented only one dose being given to the patient.

Another 10 mg of oxycodone was not accounted for.

Two 5 mg oxycodones were withdrawn but only one was accounted for.

Two 10 mg methadone tablets were withdrawn and not accounted for.

It could not be proven that the nurse diverted narcotics for her own personal consumption, but that was not the relevant issue.

The nurse was terminated for discrepancies between the specific medication dosages she withdrew from the dispenser and the medications she documented were given to her patients.

She was guilty of misconduct justifying her termination for cause.

COURT OF APPEALS OF MINNESOTA
January 22, 2013

The Court of Appeals of Minnesota ruled her termination was justified.

Her responsibilities as an LPN included accurate documentation of administration to patients or return or wasting of her medications.

She was given a copy of the facility's policies during her employee orientation and periodically advised in writing of changes. An employer has the right to expect that an employee will abide by the employer's policies.

The Court discounted the LPN's argument that she was not adequately trained, finding that not credible.

She was not given any warning prior to her termination, but being a nurse she was not entitled to a warning that failing to document medications is a serious violation of nursing standards. **Jewett v. Healtheast, 2013 WL 216398 (Minn. App., January 22, 2013).**