Newsletter subscription includes online access to archived articles on 500+ nursing law topics.
For details click www.nursinglaw.com Thank you!

Suicide Attempt: Court Finds No Nursing Negligence, No Spoliation Of The Evidence.

A patient attempted suicide by hanging himself in the bathroom of his hospital room. He survived but suffered irreversible brain damage and now must live in a nursing home. His guardian filed suit against the hospital.

Nursing Negligence Alleged in Suit

The lawsuit alleged the patient's nurse was negligent for unlocking his bathroom and allowing him to go in alone to take a shower, for not locking the bathroom when it was not immediately in use and for not checking on the patient as often as his suicidal condition required.

Staffing / Spoliation of the Evidence

The lawsuit also tried to fault the hospital for inadequate staffing, that is, the staffing on duty did not permit one-to-one supervision.

Allegedly the staffing was insufficient under a hospital staffing policy memo in effect at the time of the hanging which had been reviewed, revised and destroyed by the time the patient's lawsuit was filed in court.

The jury returned a verdict in favor of the nurse and the hospital. The Supreme Court of South Dakota upheld the jury's verdict for the defendants.

The Incident

The morning after the patient was admitted, his nurse encouraged him to take a shower, believing he would feel better if he cleaned himself up. She unlocked the door to the bathroom in his hospital room to allow him to shower alone.

At the time the patient was on fifteen-minute checks.

Soon after the bathroom door was unlocked, a psychiatrist arrived to assess the patient and went into his room to talk to him. That took about forty-five minutes.

The psychiatrist left the room and went into a room next to the nursing station to chart his report.

The nurse did not see the psychiatrist leave the patient's room, nor did the psychiatrist report to her he had left the patient alone.

About fifteen minutes after the psychiatrist left the patient's room the nurse went to check on the patient. She found him hanging by the belt of his bathrobe. He was in cardiac and respiratory arrest. She resuscitated him, but not before he had sustained severe, permanent brain damage.

The patient had gone to the Sioux Falls police station the previous afternoon claiming he was suicidal. The police took him to the hospital's emergency room. He was admitted to the hospital's adult acute care unit for a twenty-four hour mental illness hold.

Early that evening a nurse assessed the patient. He continued to express suicidal intentions.

Later that evening a nurse heard a loud noise from the room and found the patient sitting on his bed with a chair on its side next to the bed. The patient had ripped his hospital gown apart and tied the pieces together as a rope.

He apparently fell off the chair while standing on it, before he had attached the rope to the ceiling. He stated he had been trying to hang himself.

Following this episode the patient was placed on one-to-one observation until the end of the p.m. shift when fifteen-minute checks were started.

Fifteen-minute checks rather than one-to-one observation was in effect at the start of the a.m. shift when the a.m. nurse determined in her professional judgment it was appropriate to unlock the bathroom door so the patient could shower.

After a patient hanged himself the hospital destroyed a policy document for staff-to-patient ratios.

His lawyers argued it was spoliation of the evidence. The court said no. The old policy was destroyed in the ordinary course of business, in a routine annual update of hospital policies.

SUPREME COURT OF SOUTH DAKOTA, 2000.

Spoliation of the Evidence

By destroying evidence healthcare professionals risk only making things more difficult for themselves.

In this case the hospital destroyed a policy document for staff-to-patient ratios in the adult acute care unit. The patient's lawyers claimed it was spoliation of the evidence. They claimed the hospital knew staffing would be a critical legal issue for them in trying to blame the hospital for the patient's hanging.

When a healthcare defendant intentionally destroys relevant evidence in anticipation of litigation, the law gives the plaintiff the benefit of an adverse inference. That is, the judge is allowed to instruct the jury to the effect the destroyed documents would have supported the patient's case if they came in as legal exhibits for the jury.

If the evidence relates to the patient's case, the defendant must be prepared to show the evidence was destroyed with no intention to defeat the patient's case.

Routine Course of Business

The court pointed out there is no spoliation of the evidence when a defendant destroys documents in the routine course of business, as opposed to doing so in anticipation of litigation.

The court ruled in this case the hospital had the right to destroy copies of its old policies as its old policies were routinely reviewed and updated on an annual basis.

However, the court stressed it was the hospital's burden of proof as the defendant in the lawsuit to show it already had a routine practice in effect of destroying old hospital policy documents before the events in this case occurred.

The Nursing Standard of Care

The court said the only real issue was the legal standard of care.

The court ruled there is no violation of the nursing standard of care for a nurse in an acute care hospital, having determined as a matter of professional judgment it is appropriate to unlock the bathroom door to let the patient take a shower, not to go back and lock the bathroom door just because a physician goes into the room to interview

(Continued on page 3)

Newsletter subscription includes online access to archived articles on 500+ nursing law topics.
For details click www.nursinglaw.com Thank you!

Patient Suicide (Continued).

the patient.

The nurse complied with the protocol in effect for fifteen-minute checks, and that was all the standard of care required.

No *Res Ipsa Loquitur*
Suicide Is Possible Without Negligence

Going hand in glove with the court's ruling on the standard of care, the court refused to apply the legal rule of *res ipsa loquitur*.

The court expressly ruled that patient suicide can happen in a hospital without any negligence by hospital personnel.

Res ipsa loquitur only applies to incidents that simply do not happen in the absence of negligence. An example where *res ipsa loquitur* would apply is when instruments or sponges are sewn up inside a surgical patient. The law says that is something that can only happen when there is negligence. The law excuses the patient of having to find proof of negligence when that happens. **Wuest v. McKennan Hospital, 619 N.W. 2d 682 (S.D., 2000).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession
ISSN 1085-4924
© 2020 Legal Eagle Eye Newsletter
Published monthly, twelve times per year.

Print edition mailed First Class Mail at Seattle, WA.

Electronic edition distributed by email file attachment to our subscribers.

E. Kenneth Snyder, BSN, JD
Editor/Publisher

PO Box 4592
Seattle, WA 98194–0592
(206) 718-0861

kensnyder@nursinglaw.com
www.nursinglaw.com

Restraint And Seclusion In Psychiatric Residential Treatment Of Individuals Under Twenty One: New Regulations From HCFA.

Effective March 23, 2001 new regulations apply to non-hospital psych residential facilities that provide inpatient psychiatric services to Medicaid patients under age twenty one.

The new regulations establish standards to protect the health and safety of young residents in the use of restraint or seclusion.

Psychiatric residential facilities are required to notify a resident, a parent or guardian of the facility's policy for use of restraint or seclusion in emergency safety situations.

The new regulations are very lengthy. We have placed the new regulations on our website at http://www.nursinglaw.com/newHCFAregulations.htm

FEDERAL REGISTER, January 22, 2001
Pages 7147 – 7164.

The Health Care Financing Administration has added the following:

Subpart G--Condition of Participation for the Use of Restraint or Seclusion in Psychiatric Residential Treatment Facilities Providing Inpatient Psychiatric Services for Individuals Under Age 21

483.350 Basis and scope.
483.352 Definitions.
483.354 General requirements for psychiatric residential treatment facilities.
483.356 Protection of residents.
483.358 Orders for the use of restraint or seclusion.
483.360 Consultation with treatment team physician.
483.362 Monitoring of the resident in and immediately after restraint.
483.364 Monitoring of the resident in and immediately after seclusion.
483.366 Notification of parent(s) or legal guardian(s).
483.368 Application of time out.
483.370 Postintervention debriefings.
483.372 Medical treatment for injuries resulting from an emergency safety intervention.
483.374 Facility reporting.
483.376 Education and training.

This is only the table of contents for the new regulations.

FEDERAL REGISTER, January 22, 2001
Pages 7147 – 7164.

LEGAL EAGLE EYE NEWSLETTER PO BOX 4592 SEATTLE WA 98194-0592
(206) 718-0861 Clip and mail or order online at www.nursinglaw.com/subscribe.htm
Print $155/year ______ Email $120/year ______
Check enclosed _____ Bill me _____ Credit/Debit card ______
Visa/MC/AmEx/Disc No. ____________________
Signature ____________________
Expiration Date __________ CVV Code ______ Billing ZIP Code _______

Name ____________________
Organization ____________________
Address ____________________
City/State/Zip ____________________
Email for Email Edition* ____________________

***Print subscribers: provide your email and receive Email Edition at no extra charge.**