YOUR ARTICLE IS ON PAGE TWO.

LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

August 2015 Volume 23 Number 8

Labor & Delivery: Jury Finds That Nurse, Midwife Met The Legal Standard Of Care.

A nurse and a midwife took charge of the mother's labor while all of the hospital's ob/gyn resident physicians were away at a conference.

Pitocin was started at 4:00 a.m. but by 7:00 a.m. little progress was seen.

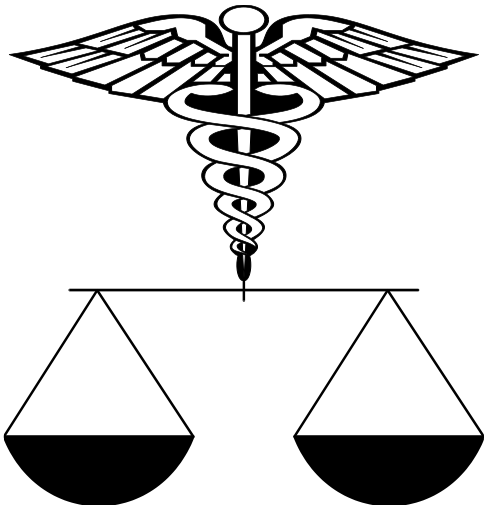
At 8:40 a.m. the nurse turned off the Pitocin because she was concerned the contractions were too close.

Following the hospital's nursing protocol, she waited twenty minutes and resumed the Pitocin at a lower rate.

When the fetal heart rate decelerated during an episode of vomiting, the nurse stopped the Pitocin altogether. O_2 was started and the mother was turned on her side.

Another deceleration soon followed. The midwife placed a fetal scalp monitor. After yet another deceleration, this time lasting two minutes, the midwife tore off the monitor strip and walked down the hall to speak with an obstetrician in his office who specialized in high-risk deliveries, while the nurse drew blood for the lab.

The obstetrician opted to wait. The mother was only fourteen and her 8 to 9 cm dilation seemed to show good progress toward a vaginal delivery, but when decelerations continued the nurse and the midwife prepped the patient for a cesarean. The baby was delivered with hypoxic brain injuries.



The midwife tore off the monitor strip and took it to the obstetrician's office down the hall from the delivery unit.

Handwritten notations on the strip indicated when O_2 was given, the mother repositioned and a vaginal exam done that showed 8 to 9 cm dilation.

There was no negligence in the nurse's or the midwife's management of the labor.

COURT OF APPEALS OF WISCONSIN
July 21, 2015

The Court of Appeals of Wisconsin upheld the jury's verdict of no negligence by the nurse, the midwife or the obstetrician.

Another midwife testified as a defense expert witness that the nurse and the midwife carefully watched and competently read the monitor strips, managed the Pitocin, gave O_2, repositioned the mother and timely and accurately reported to the obstetrician.

The obstetrician testified as an expert witness for the hospital that the labor was Category II, requiring continuous surveillance but not necessarily indicative of fetal distress.

The patient's expert testified the fetal decelerations showed a "non-reassuring" pattern. The Court ruled the obstetrician was nevertheless not required to testify in terms of reassuring and non-reassuring fetal heart-rate patterns, that terminology being obsolete since a new classification system was adopted by obstetric specialists in 2009.

The Court also accepted a pathologist's expert testimony for the hospital. Microscopic examination of the placenta revealed abnormalities which compromised the fetus but produced no outward signs the mother's caregivers could have seen. **L.D. v. Patients Fund, 2015 WL 4429090 (Wisc. App., July 21, 2015).**

Inside this month's issue...

August 2015

New Subscriptions See Page 3

IM Injections: Hospital Used Outdated Nursing Standard.

The patient came to the emergency department complaining of knee pain. The physician diagnosed a knee strain and ordered 60 mg of Toradol IM.

The patient received an IM injection from the emergency department nurse in the left deltoid of 60 mg of Toradol in 2 ml of fluid.

Immediately afterward the patient felt pain radiating up and down the arm. The next day there was pain, swelling, tingling, spasms and weakness in the arm.

An orthopedist eventually diagnosed complex regional pain syndrome post Toradol injection.

Hospital's Protocol Based On Outdated Nursing Text

The hospital's protocol was last updated two and one-half years before.

Based on the fifth edition of a standard nursing text which did not specify a maximum volume for injections into the deltoid muscle, the hospital's protocol specified a maximum volume of 5 ml for injections into the deltoid.

However, the seventh edition of that same nursing text and other nursing texts current in June 2011 when the patient was treated limited injections into the deltoid to 0.5 to 1 ml. Larger volume injections were to be given in a larger muscle in the ventrogluteal region.

Court Accepts Patient's Nursing Expert's Opinion On the Standard of Care

The Court of Appeals of Texas accepted the patient's nursing expert's opinion that the hospital's protocol for intramuscular injections violated the legal standard of care, in that the protocol was based on an outdated nursing text.

The Court threw out the local county judicial court's ruling which erroneously granted a summary judgment of no liability in favor of the hospital.

However, before the patient will be entitled to an award of damages from the hospital the patient's attorneys will have to convince a jury to accept her expert physician's opinion that her symptoms after the incident were in fact caused by the Toradol injection and not some other factor. **Bowser v. Craig, 2015 WL 3946371 (Tex. App., June 29, 2015).**

The patient's nursing expert faulted the hospital for still using an outdated source for its protocol for intramuscular injections.

The hospital's reliance on an outdated nursing text, according to the patient's expert, was a breach of the legal standard of care.

The outdated source did not specify a maximum volume for an injection into the deltoid muscle.

The hospital's standing protocol nevertheless placed a limit of 5 ml on injections into the deltoid.

Nursing texts current at the time the patient received the injection into her deltoid muscle did specify a maximum volume.

Nursing texts current at the time of the patient's injection limited injections into the deltoid to 0.5 to 1 ml of fluid, much less than the volume allowed by the hospital and less than that actually given by the emergency department nurse.

The nurse injected 60 mg of Toradol in 2 ml of fluid.

The patient still must convince a jury through expert medical testimony that the Toradol injection was the actual cause of the symptoms she has experienced since the incident in the hospital's emergency room.

COURT OF APPEALS OF TEXAS
June 29, 2015

MI After Clinic Visit: Nurse Practitioner Ruled Not Liable.

The patient was seen by a nurse practitioner in the outpatient clinic for persistent diarrhea he had been experiencing for two weeks.

The nurse practitioner, after consulting with the clinic physician, prescribed the antibacterial medication Flagyl.

After nine days on the medication the patient phoned the clinic to report that the medication was making him feel worse. He was told to keep taking it.

The next day he collapsed at home and was taken to a hospital where he died. No autopsy was performed. The death certificate pointed to a cardiovascular event with hypertension as a contributing factor.

Even if the nurse practitioner's care of the patient's gastrointestinal problem did not meet the standard of care, there is no proof that it was a causal factor in his death.

COURT OF APPEAL OF LOUISIANA
July 1, 2015

The Court of Appeal of Louisiana dismissed the lawsuit the family filed alleging negligence by the nurse practitioner and her supervising physician.

The Court discounted as irrelevant the opinions of the family's medical expert. The expert stated that the nurse practitioner should have ordered a complete metabolic panel, sent a stool sample to the lab, scheduled a follow-up appointment within forty-eight hours and taken into consideration that Flagyl can worsen diarrhea.

For treatment of the gastrointestinal problem the family's medical expert may have correctly stated the legal standard of care, and identified breaches of the standard of care by the nurse practitioner, but it was only speculation that that in any way caused or contributed to the patient's death from an apparent heart attack, the Court said. **Lee v. McGovern, __ So. 3d __, 2015 WL 4002334 (La. App., July 1, 2015).**

Hearing Impairment: Court Looks At Patient's Disabled Family Member's Legal Rights.

The patient's mother was informed by phone that the patient, her young adult daughter, was being taken to the hospital.

The mother has been completely deaf since birth. When she arrived at the hospital she made a request for an American Sign Language (ASL) interpreter.

Since there was no ASL interpreter available, and the hospital's video remote interpreter (VRI) equipment was down, a nurse simply passed the mother a handwritten note saying, "Your daughter is dead." The daughter had been brought in already deceased from a heroin overdose, but nothing was explained to the mother.

The mother wanted to find out what had happened to her daughter. A meeting was scheduled at the hospital almost two months later, but when she showed up with an attorney hospital officials balked at seeing her. The mother sued the hospital.

Disability / Reasonable Accommodation

The US Americans With Disabilities Act (ADA) and supporting Federal regulations give persons with communication disabilities the right to auxiliary aids to make their communication with healthcare providers comparable in effectiveness to the communication that non-disabled patients and family members enjoy with their healthcare providers.

Patients and family members with communication disabilities are given rights by the US Americans With Disabilities Act (ADA).

However, legal barriers sharply limit enforcement of those rights through civil lawsuits.

Disabled patients and family members also have rights under the US Rehabilitation Act.

A lawsuit for damages is permitted by the Rehabilitation Act, but can succeed against a healthcare provider only if there has been deliberate indifference to the needs of a person with a communication disability.

Although the hospital's VRI was down at the time, the hospital was in compliance with regulations, making it difficult to say the hospital was deliberately indifferent.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
July 7, 2015

However, the ADA does not allow a lawsuit for damages by a disabled patient or family member denied reasonable accommodation to a disability by a healthcare provider.

A disabled person can sue for a court injunction barring future discrimination by a particular healthcare provider that has denied the person reasonable accommodation, but only if the disabled person can show a strong likelihood that he or she will need the provider's services again in the future and will be denied effective communication in such a future encounter.

Although the mother was a patient in the hospital in the past, it was inconclusive that the hospital would violate her rights in the future, the US District Court for the Middle District of Pennsylvania ruled.

Lawsuits for Damages

The US Rehabilitation Act does allow a disabled patient or family member to file a civil lawsuit for damages for discrimination against a healthcare provider that receives Medicare or Medicaid funds.

However, to win a legal case the disabled person must show that the healthcare provider was guilty of deliberate indifference to the disabled person's special needs.

A temporary lapse is not deliberate indifference. Federal standards do not require hospitals to have on-site ASL interpretation. VRI complies with Federal regulations. The hospital later got its VRI up and running and then got a new VRI vendor, showing its regard for deaf persons' special needs. **Shaika v. Gnaden Huetten, 2015 WL 4092390 (M.D. Penna., July 7, 2015).**

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Epilepsy: Court Dismisses Aide's Disability Case.

In her pre-employment interview at a skilled nursing facility a nurses aide volunteered that she was taking medication for epilepsy.

However, she did not disclose the fact that she had experienced a grand mal seizure on the job at her previous employer, a nursing home, and was then terminated over concerns for patient safety.

The skilled nursing facility hired her at her interview. Two months later she had a grand mal seizure on the job while monitoring a patient one-on-one.

After being hospitalized for her seizure the aide provided her employer with a return-to-work letter from her physician.

The physician stated she was fit to return to work, provided she avoided activities where loss of consciousness could create a risk of harm to herself or others such as driving, operating machinery or working in high places.

Based on the physician's letter the skilled nursing facility elected to terminate the aide's employment. She later claimed she requested a transfer to housekeeping or the laundry. The facility stated that even if such a request was actually made, there were no such positions open at the time.

Court Turns Down
Disability Discrimination Lawsuit

The United States District Court for the Northern District of Ohio ruled there was no question the aide had a disability and was terminated for her disability.

However, a disabled individual is not a qualified individual with a disability who has rights under the anti-discrimination laws if he or she poses a direct threat to the health or safety of others which cannot be eliminated by a reasonable accommodation, the Court pointed out.

Other US courts have already ruled that a direct-care nursing employee who experiences loss of consciousness on the job poses a direct threat to patient safety.

The risk of a seizure for this aide was unpredictable with no warning symptoms and the chance of recurrence was high. It could happen at a critical moment like while moving or assisting a patient, leading to a high risk of patient injury from a fall.

Baskerville v. Pleasant Lake, 2015 WL 4112504 (N.D. Ohio, July 7, 2015).

The decision to terminate the aide's employment was based on the serious safety threat to the facility's elderly patients posed by her risk of a seizure, made evident by her having had a seizure while working on the job.

There is no question the aide's epilepsy is a disability or that her disability was the reason for her termination.

However, she is not a qualified individual with a disability who can perform the essential functions of her job with or without reasonable accommodation.

A disabled individual is not qualified for a specific job if he or she poses a direct threat to the health or safety of others which cannot be eliminated by a reasonable accommodation.

To decide if a direct threat exists the court must consider the duration of the risk, the nature and severity of the potential harm, the likelihood the harm will occur and the imminence of the potential harm.

A slightly increased risk of harm is not considered a direct threat.

Only a high probability of substantial harm is considered a direct threat.

UNITED STATES DISTRICT COURT
OHIO
July 7, 2015

Disability Discrimination: No Interactive Communication.

A nursing home employee requested and was given twelve weeks of unpaid Family and Medical Leave Act leave on account of chronic back pain which prevented her from working.

At the end of twelve weeks she handed in a form filled out by her physician stating that she was still unable to work for at least another month.

Management at the nursing home unilaterally decided her condition was most likely permanent and terminated her employment.

The former employee sued her former employer for disability discrimination.

The employer has the responsibility to initiate an interactive communication process with a disabled employee to see if reasonable accommodation is possible.

UNITED STATES DISTRICT COURT
WISCONSIN
June 24, 2015

The US District Court for the Eastern District of Wisconsin ruled it was not clear whether this individual's disability, her chronic back pain, made her completely unable to work ever again and thus not a qualified individual with a disability.

No Interactive Communication Process

What was clear was that her employer failed to initiate an interactive communication process with her to determine if a reasonable accommodation was possible that would allow her to return to work.

That is, additional time off from work as prescribed by her physician may or may not have eventually resulted in her being able to return to work.

Time off for recuperation is one form of accommodation an employer must consider as a possible reasonable accommodation that is within a disabled employee's legal rights under the anti-discrimination laws.

Cross v. Golden Living, 2015 WL 3887161 (E.D. Wisc., June 24, 2015).

Whistleblower: Verdict For CRNA.

A certified registered nurse anesthetist (CRNA) practiced in the hospital's obstetrics department as an independent contractor associated with an anesthesia professional practice group.

She reported an obstetrician to the hospital's ethics committee who performed a cesarean on a nineteen year-old patient who voiced her preference for a vaginal delivery and her opposition to a cesarean.

The patient did sign a consent form, but only after the obstetrician reportedly told her, "Well, if you want a brain-damaged or a dead baby, don't blame me," and did not explain to his patient the risks and the benefits of the procedure.

After she reported the obstetrician the hospital reduced the CRNA's hours to the point she had to drop her association with her practice group and go elsewhere.

A physician violates the law who fails to obtain the patient's informed consent for a surgical procedure.

A nurse who reports a physician's violation of the law cannot be subjected to retaliation.

COURT OF APPEALS OF TEXAS
June 27, 2015

The Court of Appeals of Texas upheld a verdict of $822,480.00 from the hospital.

CRNA Was Not an Employee

An important legal wrinkle in this case was that the CRNA was not an employee of the obstetrician or the hospital. The whistleblower laws as written protect whistle-blowing employees from reprisals by their employers, but may not apply to independent contractors.

The Court recognized nevertheless that the CRNA had legal rights under a common law theory of wrongful interference with her business relationship with her practice group. That relationship was damaged by the hospital reducing her hours as retaliation for reporting the obstetrician. **El Paso v. Murphy, __ S.W. 3d __, 2015 WL 4082857 (Tex. App., June 27, 2015).**

Worker's Comp: Agency Nurse Is Hospital's Borrowed Employee Who Cannot Sue.

Worker's compensation benefits are the exclusive remedy for compensation from the employer for an injury sustained by an employee on the job.

The worker's compensation law does not prevent an employee injured on the job from suing a party who is not his or her employer.

If negligence can be proven by a party who is not the employee's employer, the injured employee can recover damages for pain and suffering, mental anguish and emotional distress. Compensation for those types of damages is not paid out under worker's compensation.

A civil negligence lawsuit could also provide compensation to an injured employee for future disability and future wage loss on a more generous basis than the limited disability schedules available under the worker's compensation law.

In this case, however, the law considers the agency nurse to be the hospital's employee, borrowed by the hospital on loan from the agency.

She is essentially a hospital employee and cannot sue the hospital.

APPELLATE COURT OF ILLINOIS
July 16, 2015

An agency nurse was injured in a slip and fall while working at the hospital.

Her agency paid more than $50,000.00 to settle her worker's compensation clam. The hospital was not involved in that part of the case. Then the nurse filed a civil negligence lawsuit against the hospital for further compensation.

The hospital defended the lawsuit on the basis that the agency nurse was essentially a hospital employee.

A hospital employee would not be allowed to sue the hospital, because the worker's compensation law defines worker's compensation benefits as the injured employee's exclusive remedy *vis a vis* the employer for an on-the-job injury.

The Appellate Court of Illinois agreed with the hospital.

Borrowed Employee Rule

The agency was the nurse's common law employer. Based on its contract with the hospital the agency paid her wages, withheld employment, worker's compensation and unemployment taxes and paid for her health benefits.

However, the key fact was that the hospital had the sole right to direct and control the way she performed her work while on the job at the hospital. That made her essentially a hospital employee.

She worked the same shifts as the hospital's own common law employees. She was told when and where to report and received her assignments and instructions from the same supervisors as the hospital's employees with whom she worked closely together. The hospital had the right to fire the nurse if it chose, not necessarily from the agency, but from further work at the hospital.

No one from the agency was present in the hospital or had any direct involvement in the nurse's supervision.

The law considers the agency the loaning employer and the hospital the borrowing employer. Both employers are immune from a civil negligence lawsuit, based on the exclusive remedy provision of the worker's compensation law. **Riechling v. Touchette, __ N.E. 3d __, 2015 Ill. App. 5th 140412 (Ill. App., July 16, 2015).**

Long-Term Care: New Standards Proposed By CMS For Medicare/Medicaid Participation.

On July 16, 2015 the US Centers for Medicare & Medicaid Services (CMS) published a 103 page announcement in the US Federal Register containing proposed new regulations governing Medicare- and Medicaid-participating nursing facilities, skilled nursing facilities and hospital "swing beds."

According to CMS, the new regulations are required by the Patient Protection and Affordable Care Act of 2010.

The proposed new regulations are not mandatory at this time.

CMS as a Federal agency must first publish proposed new regulations in the Federal Register, accept public comments for sixty days and then consider the public comments it receives before issuing new regulations in final mandatory form.

We are only spotlighting certain items from the points CMS itself has identified as the highlights of the lengthy and complex proposed new regulations.

On July 16, 2015 the US Centers for Medicare & Medicaid Services (CMS) announced proposed comprehensive changes to Federal regulations for long-term care facilities and hospitals' "swing beds."

The proposed changes are not mandatory at this time. CMS is accepting public comments until September 14, 2015.

We have CMS's announcement on our website at http://www.nursinglaw.com/CMS071615.pdf

The new regulations begin on page 79 of the PDF document, Federal Register page 42245.

FEDERAL REGISTER July 16, 2015
Pages 42168 - 42269

Freedom From Abuse, Neglect, Exploitation (§483.12)

A facility cannot employ any individual who has had disciplinary action taken against his or her professional license by a state licensure body as a result of a finding of abuse, neglect, mistreatment of a resident or misappropriation of a resident's property.

Facilities must develop and implement written policies and procedures that prohibit and prevent abuse, neglect, mistreatment and misappropriation of residents' property.

Transitions of Care (§483.15)

Formerly "Admission, transfer and discharge rights."

Specific information including history of present illness, reason for transfer and past medical/surgical history must be exchanged with the receiving provider or facility when a resident is transferred.

Comprehensive Person-Centered Care Planning (§483.21)

The facility must develop a baseline care plan for each resident within forty-eight hours of admission which includes instructions to provide effective and person -centered care that meets professional standards of quality care.

The resident's care plan must include any specialized services or rehab services the facility will provide according to the resident's Preadmission Screening and Resident Review. If the facility disagrees with the PASARR, the rationale must be documented in the medical record.

The interdisciplinary team which develops the comprehensive care plan now must include a nurses aide, a member of the food and nutrition services staff and a social worker.

Discharge planning must include a reconciliation of all discharge medications with the resident's admission medications, prescribed and over-the-counter.

Quality of Care and Quality of Life (§483.25)

Residents must receive necessary pain management. Existing requirements for nasogastric tubes are being modified to reflect current standards of clinical practice.

Nursing Services (§483.35)

A competency requirement for nursing assistants will be added to standards for determining the sufficiency of nursing staffing in addition to the number of residents, resident acuity, range of diagnoses and the contents of their care plans.

Nursing staffing requirements will include necessary behavioral health care and services to residents in accordance with their comprehensive assessments and plans of care, that is, behavioral health training will be required for the facility's entire staff.

Pharmacy Services (§483.45)

Residents who have not used psychotropic drugs (formerly "antipsychotic drugs") may not be given psychotropic drugs unless medically necessary.

Residents who do receive psychotropic drugs must be given gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue use of psychotropic drugs.

PRN orders for psychotropic drugs are to be limited to forty-eight hours duration, unless the primary care provider has reviewed the need for the medication and documented the rationale for an extended order in the resident's clinical record.

Dental Services (§483.55)

A resident may not be charged for the loss or damage to dentures that is determined to be the facility's fault.

Referral for lost or damaged dentures must be made within three business days unless extenuating circumstances can be documented. The resident must be given assistance to apply for reimbursement.

Food and Nutrition Services (§483.60)

Suitable alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside scheduled meal times, in accordance with the resident's plan of care.

Residents are not prohibited from consuming foods not produced by the facility. The facility must have a policy for use and storage of foods brought to residents by family members and other visitors.

FEDERAL REGISTER July 16, 2015
Pages 42168 - 42269

Nurse Writing Prescriptions: Court Discusses Hospital's Liability.

A nursing supervisor in the hospital's surgery department reportedly had an arrangement with an independent contractor physician who practiced in the hospital to use his prescription pad and DEA number to write occasional prescriptions for her own family and friends.

She wrote several prescriptions for a coworker for the oral antibiotic clindamycin for persistent jaw pain, which the coworker filled at the hospital's pharmacy.

After the pain did not resolve the coworker went to a physician who switched him to IV vancomycin. By then the patient's osteomyelitis had progressed to necrosis in the jaw bone.

The hospital cannot be sued on a legal theory of medical malpractice for the nurse's negligent diagnosis and medication order.

That was wholly outside the scope of her job as a nurse for the hospital.

However, certain people at the hospital knew what she was doing, in particular the hospital pharmacist who filled the nurse's prescriptions, and someone should have stopped her.

UNITED STATES DISTRICT COURT
ARKANSAS
June 30, 2015

The US District Court for the Western District of Arkansas saw evidence that the hospital was implicitly aware that the nurse, a hospital employee, was engaged in ongoing wrongful conduct, practicing medicine illegally, which posed a risk of harm to other persons.

That awareness required the hospital to take action to stop what its employee was doing and made the hospital liable for the consequences. **Isham v. Booneville, 2015 WL 396701 (W.D. Ark., June 30, 2015).**

Sexual Assault, CNA vs. Patient: Court Considers Hospital's Liability For Damages.

The patient's case against the hospital relies on two legal theories of liability, negligent hiring and negligent supervision and retention as an employee.

An employer is liable to an innocent victim for negligence in the decision to hire an employee who perpetrates a wrongful act, but only if there is sufficient evidence that the employer knew or reasonably should have known of the employee's tendency toward certain behavior similar to that which produced the injury sustained by the innocent victim.

Once an employee has been properly hired, the employer still has an ongoing legal duty not to retain an employee the employer learns or reasonably should have learned poses a risk of harm comparable to the harm suffered by the innocent victim.

In this case there was nothing wrong with the application process or the decision to hire the CNA.

However, after he was hired there was a credible report of an aggressive, non-consensual physical contact with a vulnerable female patient.

COURT OF APPEALS OF GEORGIA
July 6, 2015

An adult female patient was sexually assaulted and raped in her hospital room by a hospital CNA.

Fearing reprisals, she did not report it right away. However, three days later when she had to speak frankly with her doctor about her new abdominal pain she revealed what had happened.

The CNA was arrested and pled guilty to a criminal charge of rape.

Court Ruling On Civil Allegations Against the Hospital

The victim and her husband sued the hospital for civil negligence for hiring the CNA in the first place and for civil negligence for failing to supervise him and for keeping him on the hospital's staff.

The Court of Appeals of Georgia threw out the allegation of negligent hiring but let the case go forward on the allegation of negligent supervision and retention.

No Negligent Hiring

The hospital obtained a written employment application, interviewed the CNA, confirmed his prior employment, verified his CNA certification and obtained a criminal background check. No adverse information came up except for a six-year-old misdemeanor for passing a bad check.

The Court ruled there was no basis at the time of his hiring to suspect the CNA was capable of a sexual assault.

Negligent Supervision, Retention

After he was hired there was a reported incident where the CNA inappropriately touched a vulnerable female patient.

The Court characterized that incident five years earlier as an aggressive, non-consensual sexual contact which put the hospital on notice that the CNA posed a threat of the same sort of harm the patient suffered. Prior notice is a basic element for the hospital to be held liable.

Nevertheless, the Court was not convinced that the CNA's employment history of complaints of rough, rude and derogatory behavior toward female patients, and a bad attitude, put the hospital on notice that he posed a threat of a sexual assault upon a vulnerable patient. **Little-Thomas v. Select, __ S.E. 2d __, 2015 WL 4069534 (Ga. App., July 6, 2015).**

LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Stevens-Johnson Syndrome: Court Ruling On Nurses' Role In Medication Side Effects.

A young woman suffered a psychological breakdown in the courtroom when her bail was revoked and she was ordered jailed on a charge of domestic violence.

She was taken to a hospital psych unit and was diagnosed with dipolar disorder. The psychiatrist ordered Lamictal 25 mg twice per day.

Lamictal carries some risk of serious, possibly fatal skin conditions, Stevens-Johnson Syndrome and Toxic Epidermal Necrosis.

After a few days she was discharged from the hospital directly to the county jail. In the jail she began to show signs of a serious skin condition. A jail corrections officer kept giving her the Lamictal. No doctor or nurse was on duty in the jail to assess her condition.

After a few days in jail the patient was taken to the E.R. at the same hospital where she was a psych patient, this time for her worsening skin condition. When her skin deteriorated even further she was moved to a university medical center's ICU for nine days with a severe rash affecting ninety-nine percent of her body.

The patient filed suit against the first hospital and the county jail.

Informed Consent

The US District Court for the Middle District of Alabama saw a problem with the fact the psychiatrist at the first hospital failed to explain the risks and benefits of Lamictal and did not get the patient's informed consent.

However, the Court ruled that the nurses who gave the medication were not responsible for obtaining the patient's informed consent. Informed consent is not a nursing responsibility.

Charting Medications In the E.R.

It is still unresolved at this point whether the patient told the E.R. nurses during her second admission that she had been given Lamictal. The Court said it would be a breach of the standard of care for a nurse to fail to chart a medication the patient told the nurse she was taking.

The Court brought up the fact that the E.R. nurses did not review the patient's records from her first hospitalization at the same hospital. However, since the patient's lawsuit failed to make the allegation that that was a negligent error or omission the Court could not rule on the issue one way or the other. **McBride v. Houston County, 2015 WL 3892715 (M.D. Ala., June 24, 2015).**

Advance Directive: Hospital's Nurses Failed To Contact Agent, Did Not Honor Advance Directive.

Two years before her hospitalization the elderly patient signed an advance directive for healthcare naming her granddaughter with whom she lived as her healthcare agent.

When the patient was hospitalized for pneumonia the granddaughter gave the hospital a copy of the advance directive and told various hospital caregivers that no heroic measures were to be initiated to prolong her life.

In compliance with hospital policy the advance directive was inserted prominently in the front of the chart.

Late at night shortly after surgery to resect lung tissue the patient went into respiratory distress.

The ICU nurses did not contact the granddaughter but instead phoned the surgeon at home and got permission for intubation by the E.R. physician.

A hospital can be liable to the family for the patient's avoidable pain and suffering after the patient's wishes as expressed in an advance directive have been ignored.

There was a basic problem of lack of informed consent for the intubation.

The patient could not give her own consent and her properly-designated agent had already declined.

COURT OF APPEALS OF GEORGIA
June 17, 2015

Once the patient was intubated hospital protocols for DNR extubation came into play and she was not allowed to expire for ten days while numerous medical procedures were performed.

The Court of Appeals of Georgia let the family's lawsuit against the hospital go forward.

The Court ruled the ICU nurses who got the surgeon to order the patient intubated should have made a good faith effort to rely on the granddaughter's directions and decisions as the patient's designated health care agent, the nurses' legal duty under state law.

The nurses were aware of the advance directive the patient had signed, and the granddaughter named as agent had expressly told them not to intubate the patient without contacting her. **Doctor's Hosp. v. Alicea, __ S.E. 2d __, 2015 WL 3757027 (Ga. App., June 17, 2015).**