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

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

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

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

Working is a major life activity.

UNITED STATES DISTRICT COURT
WASHINGTON
August 15, 2011

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

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

No Age Discrimination

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

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

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

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

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

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

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

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

UNITED STATES DISTRICT COURT
NEW YORK
July 28, 2011

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

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

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

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

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

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

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

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

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

SUPERIOR COURT OF PENNSYLVANIA
July 22, 2011

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

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