

Hospital Negligence: Hospital's Nurses Spoke With Patient's Family's Attorneys.

The patient's family's lawsuit arose out of a mix-up in the hospital's surgical department that resulted in the patient's death.

The ventilator-dependent patient was being moved from his room to the surgical department for a tracheostomy. On the way he was being bagged by a first-year resident physician. When they got to the surgical department they were informed the surgery could not go forward because there was no anesthesiologist available. The resident decided it was best for this patient to wait in the post-anesthesia recovery room, but they were denied entrance because he was not a post-anesthesia patient. The resident dropped him off in the pre-surgical holding area.

About an hour later the patient was found in the pre-surgical holding area without a pulse. A code was called but the patient died.

The family's lawsuit alleged negligence due to inadequate nursing assessment, monitoring and care in the pre-surgical holding area as well as a wider failure by the hospital to have policies and procedures in effect to cover the situation of a pre-surgical patient like this one with very special and urgent medical needs.

At this stage in the litigation the New York Supreme Court, Kings County, has not yet ruled on the basic issue of negligence but is still setting the rules for pre-trial evidence gathering.

Patient's Lawyers Contacted

Present and Former Nursing Employees

The ethical disciplinary rules for lawyers make it improper for a lawyer to communicate directly with persons on the opposite side of a lawsuit without going through the lawyer or lawyers representing those persons. If the opposite party is a corporation a lawyer may not directly contact the corporation's present employees.

The family's lawyers were not out of bounds contacting the now-retired head of surgical nursing at the hospital, as he was not a hospital employee at the time he was contacted.

However, the family's lawyers were wrong to send their own employee, a private investigator, to contact one of the hospital's present supervisory surgical nurses. The Court expressly ordered the lawyers to cease and desist and ruled that any statement given to the investigator by that nurse will not be admissible in court. Dixon-Gales v. Brooklyn Hosp. Ctr., __ N.Y.S.2d __, 2012 WL 786854 (N.Y. App., March 7, 2012).

Medication Misappropriation: Nurse Gave Friend Heparin, Board Revokes Nursing License.

A registered nurse obtained Heparin from the facility where he worked and administered it to a personal friend who was a patient at another hospital where the nurse did not work.

The friend's medical diagnosis or the nurse's rationale for giving the medication was not explained in the court record.

The state Board of Nursing revoked the nurse's license for misappropriating medication, failing to meet minimal standards of practice and engaging in unprofessional conduct.

Disciplinary action against a nurse for misappropriation of medication most commonly involves theft of narcotics by a nurse for the nurse's own use, but there is no reason it cannot apply to other medications or to medication given to someone else.

Unprofessional conduct as grounds for disciplinary action against a registered nurse can include misappropriating medication and engaging in actions for which the licensee is not authorized by law or qualified by reason of training and experience.

However, the Board of Nursing is required to specify the range of penalties before the fact.

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Failing to meet minimum standards of practice can include actions which are beyond the scope of the licensee's training and experience. This nurse had no authority to prescribe medication for his friend or to administer any medication without a physician's order.

The District Court of Appeal of Florida, even though the nurse basically admitted what he did, nevertheless overturned the Board's revocation of his license on technical legal grounds.

The Board has the authority to impose a harsher penalty for a first offense than the usual penalty of a fine, license suspension and probationary period, but the Board never took the required step of formulating guidelines before the fact defining what circumstances would justify such a harsher penalty. Fernandez v. Dept. of Health, __ So. 3d __, 2012 WL 933082 (Fla. App., March 21, 2012).