LEGAL EAGLE EYE NEWSLETTER

For the Nursing Profession

A free sample copy of our eight-page monthly newsletter starts on the next page.

We keep our readers informed of the latest important legal developments affecting nurses in hospitals, skilled nursing facilities, extended care nursing centers and home health agencies.

Each month we cover the latest U.S. Federal and state court decisions and new Federal regulations that pertain to nursing.

We focus on nurses' professional negligence, institutional risk management, employment discrimination, professional licensing, Medicare and Medicaid.

Our readers are busy professionals in clinical nursing, nursing management, healthcare quality assurance, risk management, legal nurse consulting and law.

Our goals are to reduce nurses' fear of the law and litigation. Nurse managers need to prevent legal problems before they happen. Clinical nurses should be familiar with the law as it affects nursing and how the courts apply the law to clinical situations. Our newsletter highlights the law, giving nurses confidence to act appropriately in certain circumstances. We get to the point and spot the latest developments.

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LEGAL EAGLE EYE NEWSLETTER

June 2012 *For the Nursing Profession* Volume 20 Number 6

Hospital Emergency Room Care: Court Finds No Nursing Negligence, Dismisses Lawsuit.

The patient arrived by ambulance in the hospital's emergency department.

He had been injured by being hit in the back of the head by a softball while running from third base to home during a game. The information obtained by the paramedics was that when struck he fell face-first to the ground and briefly lost consciousness.

Prompt Nursing Triage

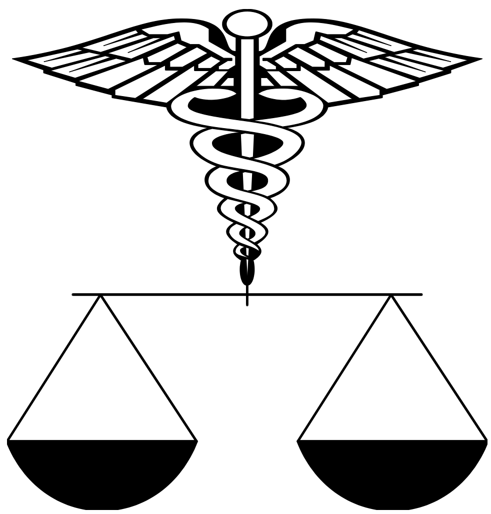
A nurse triaged the patient in the hallway of the emergency department twelve minutes after arrival. The patient was still on the paramedics' longboard and was still wearing a C-collar.

The triage nurse documented that he was alert and oriented and his vital signs were within normal limits.

He complained of pain in the back of his head, tingling in his right arm and nausea. He was given medication for nausea ten minutes later.

A physician saw him a few minutes after that and ordered a CT, which showed left parietal acute epidural hematoma and a depressed skull fracture. The physician obtained a consult from a neurosurgeon.

The E.R. nurses continued to monitor the patient's condition which remained basically unchanged for almost four hours after he first arrived in the emergency department.



The E.R. nurses and other non-physician staff at the hospital properly triaged the patient, monitored and reassessed his condition during the night, recognized signs of significant changes in his condition, communicated those changes to the physician and promptly carried out all physicians' orders while he was under their care.

CALIFORNIA COURT OF APPEAL
May 16, 2012

Close Monitoring By E.R. Nurses

At 2:40 a.m. an E.R. nurse placed a call to the neurosurgeon to get him back to the bedside because the patient had become confused, his pupils were unequal and he might have been having a seizure. The neurosurgeon intubated him and medication was started.

The physicians wanted to transfer him to a tertiary trauma facility. However, at 3:15 a.m. it was not possible to arrange immediate transport via air ambulance and the delay involved in ground transport was deemed unacceptable, so hematoma evacuation surgery was done there at the same hospital and he was sent to the ICU afterward.

No Nursing Negligence
Standard of Care Was Met

The California Court of Appeal accepted the testimony of the hospital's expert, a physician board-certified in emergency medicine, that there was no failure by the hospital's nurses or other non-physician personnel to assess the patient, to monitor and reassess the patient on an ongoing basis during the night, to recognize the signs of significant changes in his condition, to communicate those changes to the physician and all physicians' orders were carried out in a timely fashion. **Kunkel v. Universal Health Services, 2012 WL 1726936 (Cal. App., May 16, 2012).**

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Emergency Room: Patient Falls From Bed, Nursing Negligence Found.

The patient appeared to suffer a seizure while she was in a store Christmas shopping with her husband and was taken by ambulance to the hospital.

While lying on a bed in the emergency department the patient had another seizure. Her husband was sitting on a chair in the room and went to help her, but he was unable to keep her from falling on the floor, landing on her face and sustaining facial bone fractures.

The patient apparently had a second seizure while lying on a bed in the emergency department and fell to the floor, the bed rails not having been raised by the E.R. nurse.

DANE COUNTY CIRCUIT COURT
WISCONSIN
February 24, 2012

The jury in the Circuit Court, Dane County, Wisconsin reportedly accepted testimony from two experts, one a physician/expert in emergency medicine and the other a nurse/expert in emergency nursing standards, who testified on the patient's behalf.

According to the patient's experts, it is a shared emergency medicine and emergency nursing responsibility to implement seizure precautions for a patient in whom seizure activity should be anticipated. Seizure precautions include raising the bed rails on both sides of the bed, the patient's experts said.

The nurse apparently left one side rail down when she exited the patient's room to care for another patient elsewhere.

The physician came into the room to discuss the results of the CT scan with the patient and her husband, and then reportedly exited the room himself without recognizing the need to raise or have someone raise the other bed rail. **Shedivy v. Meriter Hosp., 10CV-5270 (Circuit Ct., Dane Co., Wisconsin, February 24, 2012).**

Outpatient Appointments: Jury Faults Clinic's Nurse, Procedures.

The patient went to see her primary care physician after she awoke with severe leg and back pain. She had been seeing the same physician for a lumbar disc syndrome for more than two years.

While she was there her physician reportedly phoned a neurology clinic and spoke with the on-call physician, then told the patient to get an appointment to see the neurologist the next day, but if there was a significant increase in her pain she should go to the emergency room instead.

The patient phoned the neurology clinic the next day and said that her physician had spoken with a doctor there the previous day who wanted her seen that day, the day she was calling.

A nurse told her it would take at least three weeks to get an appointment and someone would call her back. The patient kept calling back and finally was given an appointment the following day.

The next day when she awoke she discovered she had a foot-drop. When she went to her appointment she told the physician it had started during the night before.

Jury Awards Damages

The jury agreed with the patient that the nurse in the neurology clinic should not have discounted the patient's need for an appointment that same day, given that a physician in the clinic had recommended that to the patient's physician. The clinic should have had a procedure to screen incoming calls for details that pointed to an immediate need to be seen, the jury was told by the patient's expert witnesses.

At the same time the jury found the patient herself 49% at fault for not going to the E.R. as she was told.

The Court of Appeals of Tennessee ordered a new trial of the case. Even if the nurses mishandled the patient's legitimate request for a same-day appointment the evidence was equivocal at best that an appointment that same day would have made a real difference in the eventual outcome. **Kellon v. Lee, 2012 WL 1825221 (Tenn. App., May 21, 2012).**

Service Animal: Hospital Must Accommodate Visitor's Disability.

A family member came to visit her mother who was a patient in the hospital. The visitor had with her a dog on a leash wearing a blue cape with two patches reading "Service Dog."

A security guard stopped her and insisted she register her dog before entering the hospital. She refused, stating that her dog was a service animal and was fully vaccinated and she had no legal obligation to register the animal.

The security guard detained her at the door while he summoned his supervisor. The supervisor allowed the visitor to enter the hospital. She returned several more times later the same week and was allowed to come in with her dog without incident.

A hospital is a place of public accommodation which the US Americans With Disabilities Act says must allow patrons to enter with their service animals.

UNITED STATES DISTRICT COURT
ARIZONA
May 15, 2012

The US District Court for the District of Arizona dismissed the disability discrimination lawsuit the visitor filed against the hospital.

The Court noted that a Federal regulation (28 C.F.R. § 36.104) defines the term "service animal" for purposes of the Americans With Disabilities Act. It was not clear that this dog met the strict legal definition by being trained to do work or perform tasks for a disabled individual.

Leaving that issue aside, the basis for the Court's ruling was that a brief detention while straightening out the issues was not sufficient grounds for a lawsuit against the hospital. Because the hospital let her back in several more times without incident there was no reason to expect further problems requiring an injunction from the Court. **O'Connor v. Scottsdale Healthcare, 2012 WL 1717934 (D. Ariz., May 15, 2012).**

Involuntary Psychiatric Hospitalization: Patient's False Imprisonment Lawsuit Dismissed.

The patient alleged she walked into the hospital one February evening only to keep warm and not become frostbitten but when she tried to leave several nurses grabbed her, strapped her down and kept her for four days until she was released after a mental health commitment hearing.

Hospital personnel said the patient was brought to the E.R. by police because of her bizarre behavior and soon ran out of the hospital into traffic yelling that someone was going to cut her eyes out.

Based on her present intent for self-harm a hospital RN got a physician to order restraints for a four-hour period. During that time her status and the need to continue the restraints were assessed and documented every fifteen minutes.

Minutes after the restraints were started an emergency custody order was signed by a local magistrate and within a half-hour a mental health professional interviewed the patient to determine whether to file a petition for involuntary admission and treatment.

The mental health professional documented the patient was delusional and was expressing paranoid ideation that others wanted to cut off her head and poke out her eyes. The mental health professional had a judge sign a temporary detention order within the next three hours.

A civil suit for false imprisonment can be filed against someone who restrains another person's liberty without legal justification.

If adequate legal justification can be shown to exist, there is no right to sue, as is true in this case.

The hospital obtained a temporary detention order from a magistrate which gave the hospital legal authority to detain, treat and care for the patient until a full-scale commitment hearing could be held.

The patient has no grounds to sue the hospital for civil battery. The physician authorized restraints to protect the patient from herself during the period of time covered by the temporary detention order which gave the hospital authority to hold her and provide necessary medical care.

UNITED STATES DISTRICT COURT
VIRGINIA
April 25, 2012

The temporary detention order allowed the patient to be kept involuntarily pending a full-scale court hearing four days later. At the hearing the judge ruled that further involuntary mental health treatment was not warranted, at which point the patient was promptly released.

Lawsuit Against Hospital Dismissed

The US District Court for the Eastern District of Virginia dismissed the lawsuit the patient filed against the hospital.

In passing the Court pointed out that the patient was actually held under the temporary detention order a day longer than the usual four-day maximum allowed by state law before a hearing was held on the issue of long-term detention for involuntary psychiatric care.

That was not a problem because the fourth day was Monday, February 16 which was President's Day in 2010, a legal holiday when no court hearings were held.

No Negligent Infliction Of Emotional Distress

The Court dismissed the allegations in the patient's lawsuit of negligent infliction of emotional distress because there was no proof the hospital committed any negligence in her care.

Even if the hospital was authorized to hold her involuntarily by a court-issued temporary detention order, the temporary detention order by itself would not absolve the hospital from liability to the patient for negligence, if in fact it could be proven that any medical or nursing negligence was committed in her care. **Robertson v. Prince William Hosp., 2012 WL 1448101 (E.D. Va., April 25, 2012).**

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Appendicitis: E.R. Nurses Did Not Advocate For The Patient.

The patient came into the E.R. complaining of extreme pain in the lower right quadrant of his abdomen, severe nausea and vomiting for two days and a fever. Over the course of a few hours in the hospital his blood pressure dropped steadily.

The E.R. physician cancelled a urine culture that had been ordered, ordered a plain, non-contrast abdominal x-ray, made a diagnosis of urinary tract infection and sent the patient home.

A few days later the patient was seen at another hospital with a ruptured appendix. Treatment included resection of a portion of the colon damaged by infection.

The patient's expert's opinion was that the nurses should have advocated for the patient by reporting the signs and symptoms to someone other than the E.R. physician.

The hospital should have had a procedure in place to enable nurses to advocate for their patients.

COURT OF APPEALS OF TEXAS
May 10, 2012

The Court of Appeals of Texas ruled that the patient's expert witness's opinion was correct as to the E.R. nurses' legal standard of care. The case will go forward for a jury to hear all the evidence and decide the ultimate question, whether advocacy for the patient by the E.R. nurses would have changed the outcome.

The patient presented with classic signs of appendicitis which could not be ruled out as a urinary tract infection by the assessment measures that were done.

Admission to the hospital for observation, antibiotics and a surgical consult were required and the nurses should have advocated for that course, the Court believed. **United Regional v. Hardy, 2012 WL 1624153 (Tex. App., May 10, 2012).**

Overdose: Court Rules Hospital Was Not Negligent.

The patient came to the hospital by ambulance because of shortness of breath and chest pain she was not able to abate by herself with nitroglycerine.

She already had a PICC line in place through which she was receiving ampicillin for an abscess on her arm.

Once in the hospital, IV morphine was not working to ease her pain so she was given p.o. Dilaudid, the same medication she had been taking for pain from the abscess before coming to the hospital. A few minutes later a nurse noticed blue particles in the PICC line and called the physician.

The physician told the patient it was impossible for ingested oral medication to end up as blue particles in a PICC line and cautioned her that crushing her pills and injecting them into the line was dangerous.

The next a.m. in preparation for discharge the patient was given p.o. Dilaudid pills to take home and instructed to take them as needed for pain, pending a visit to her primary care physician the next day.

A few hours later she was found unresponsive in the bathroom, having crushed and injected the Dilaudid into her PICC line. She could not be revived.

The patient seemed to understand her discharge instructions and there was no reason to believe she would self-inject.

A hospital is not expected to confiscate personal possessions from a voluntarily admitted med/surg patient.

CALIFORNIA COURT OF APPEAL
May 11, 2012

The California Court of Appeal accepted expert testimony that the hospital was not responsible for anticipating that this individual, a voluntarily admitted med/surg patient, would crush and self-inject her Dilaudid again. The Court dismissed the family's lawsuit. **Richardson v. Contra Costa, 2012 WL 1654959 (Cal. App., May 11, 2012).**

Forgery: Nurse Convicted For Falsifying Nursing Documentation.

The patient suffered from dementia, seizures, bowel problems and COPD. He was high-risk for skin breakdown and had to be turned every two hours.

After his wife complained he was not receiving proper care an FBI agent installed a covert surveillance video camera in the patient's room at the nursing home.

The video revealed the patient's nurse did not administer some medications, did not take vital signs and did not turn him or perform incontinence care, all of which was nevertheless documented as done.

Forgery is committed when a document is falsified with intent to deceive and the deception has the potential to operate to the prejudice of another.

The nurse profited financially by being paid for work she did not perform.

COURT OF APPEALS OF VIRGINIA
May 8, 2012

The Court of Appeals of Virginia upheld the nurse's criminal conviction on four counts of forgery.

The patient was elderly and infirm. He was deprived of necessary medications and personal care. He did not get the laxatives that were ordered by his physician to be provided on a regular basis. Consistent turning and repositioning was important to prevent pressure ulcers, to keep his airways open and to stimulate bowel function.

Failure to maintain accurate records compromised his physician's and the other nurses' ability to formulate and/or modify care plans for treatments and medications, the Court pointed out.

The nurse's employer was required by state and Federal regulations to maintain accurate patient records and her misconduct could have led to civil monetary penalties, loss of licensure or closure of the facility. **Beshah v. Comm., __ S.E. 2d __, 2012 WL 1578736 (Va. App., May 8, 2012).**

Retaliation: Aide's Case Dismissed.

An employee with eighteen years on the job at the nursing home was suspended and then fired after complaining to the director of nursing and to human resources that the facility administrator was treating female staff members more favorably with whom he had been having romantic liaisons.

The premise of the fired employee's lawsuit was that by treating those female employees more favorably who were having sex with him the administrator was treating those less favorably who were not.

In general terms, Title VII of the US Civil Rights Act protects employees who are victims of sex discrimination as well as those who report sex discrimination which victimizes others.

An employee suing for retaliation or claiming protection as a whistleblower must have reported or complained about conduct that was actually illegal, or there is no right to sue.

UNITED STATES DISTRICT COURT
ALABAMA
April 26, 2012

The US District Court for the Northern District of Alabama dismissed the case.

So-called "romantic nepotism" may be unfair to other employees and is a practice most companies would frown upon in this day and age, but it is not illegal per-se and does not fit the definition of sex discrimination under the US Civil Rights Act.

It follows, the Court went on to say, that the fired employee in this case has no right to sue her former employer for retaliation. The conduct she was complaining about was not illegal.

It was not relevant, the Court said, that the company's employee handbook forbade sexual relationships between supervisors and rank-and-file employees, due to the potential legal exposure to the company for sexual harassment. That did not give the fired employee reasonable grounds to believe such conduct was in fact illegal. **Watkins v. Fairfield Nursing Ctr., 2012 WL 1566228 (N.D. Ala., April 26, 2012).**

Commode Chair: Court Says Family Cannot Sue After Patient's Fall.

A hospital CNA helped the patient to the bedside commode and told her to call when she was ready for assistance with cleansing and transferring back to bed.

The patient's daughter said she would help out by cleansing her mother and helping her back to bed. But when the daughter tried to help her 250+ lb mother off the commode one of the drop-down arm rests released and both of them fell to the floor.

The patient herself received a monetary settlement from the hospital.

Instead of calling the CNA back to help, the patient's family member volunteered to get involved.

Her desire to help is commendable, but the hospital is not responsible for the risk of injury she undertook by trying to move her obese mother by herself.

COURT OF APPEAL OF LOUISIANA
May 16, 2012

The Court of Appeal of Louisiana dismissed the daughter's lawsuit for her own injuries claimed from the incident.

The hospital had records showing that all of its eighteen commode chairs had remained in service without complaints or repairs from the time they were purchased and the director of nursing and a physical therapist testified that no problems or defects were ever reported.

It was just as plausible, the Court concluded, that the patient or the daughter somehow activated the arm-rest-release lever and that is why the arm rest dropped down, as opposed to the chair itself having been broken before or during this incident.

Either way, a hospital simply is not responsible for an injury to a family member who voluntarily gets involved in patient-care tasks, the Court said. **Cavet v. Louisiana Extended Care Hosp., __ So. 3d __, 2012 WL 1698132 (La. App., May 16, 2012).**

Skin Condition: Court Finds No Disability Discrimination.

A nursing-home CNA had a skin condition on her face diagnosed by one of her physicians as exogenous ochronosis and by another treating physician as seborrheic dermatitis.

The CNA was terminated. She claimed she was told that the nursing home was no longer able or willing to shift patient-care assignments around among her former co-workers to accommodate some residents' objections to her caring for them because of her appearance.

The nursing home claimed there were ongoing problems with her communication and patient-care skills which did not improve despite repeated counseling and opportunities for in-service training.

The definition of disability includes a physiological disorder or condition or cosmetic disfigurement affecting bodily systems, including the skin, that substantially limits the individual in the performance of a major life activity.

The CNA's physicians did not restrict her from full participation in her work.

UNITED STATES DISTRICT COURT
PENNSYLVANIA
May 17, 2012

The US District Court for the Eastern District of Pennsylvania ruled that the CNA's skin condition was not a disability for purposes of the Americans With Disabilities Act because it did not limit her ability to do her job and did not amount to a physical condition which substantially limits a major life activity.

If the individual does not have a disability, the individual cannot sue for disability discrimination in the workplace. **Deserne v. Abramson Center, 2012 WL 1758187 (E.D. Pa., May 17, 2012).**

Medicare/Medicaid: CMS Announces New Conditions Of Participation For Hospitals.

PART 482--CONDITIONS OF PARTICIPATION FOR HOSPITALS

Sec. 482.13 Condition of participation: Patient's rights.

(g)(1) With the exception of deaths described under paragraph (g)(2)of this section, the hospital must report the following information to CMS by telephone, facsimile, or electronically, as determined by CMS, no later than the close of business on the next business day following knowledge of the patient's death:

(i) Each death that occurs while a patient is in restraint or seclusion.

(ii) Each death that occurs within 24 hours after the patient has been removed from restraint or seclusion.

(iii) Each death known to the hospital that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death, regardless of the type(s) of restraint used on the patient during this time. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing, or asphyxiation.

(2) When no seclusion has been used and when the only restraints used on the patient are those applied exclusively to the patient's wrist(s), and which are composed solely of soft, non-rigid, cloth-like materials, the hospital staff must record in an internal log or other system, the following information:

(i) Any death that occurs while a patient is in such restraints.

(ii) Any death that occurs within 24 hours after a patient has been removed from such restraints.

(3) The staff must document in the patient's medical record the date and time the death was:

(i) Reported to CMS for deaths described in paragraph (g)(1) of this section; or

(ii) Recorded in the internal log or other system for deaths described in paragraph (g)(2) of this section.

The new Conditions of Participation take effect July 16, 2012.

Subjects affected by the new regulations include:

Reporting of restraint-related deaths;

Nursing care plans;

Administration of medications and blood transfusions;

Standing orders, verbal orders and authentication of orders; and

Infection control.

In addition to the excerpts reproduced here verbatim we have placed CMS's entire forty-three page May 16, 2012 Federal Register announcement on our website at www.nursinglaw.com/CMS051612.pdf with the new regulations beginning on PDF page 41, Federal Register page 29074.

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(4) For deaths described in paragraph (g)(2) of this section, entries into the internal log or other system must be documented as follows:

(i) Each entry must be made not later than seven days after the date of death of the patient.

(ii) Each entry must document the patient's name, date of birth, date of death, name of attending physician or other licensed independent practitioner who is responsible for the care of the patient as specified under Sec. 482.12(c), medical record number, and primary diagnosis(es).

(iii) The information must be made available in either written or electronic form to CMS immediately upon request.

Sec. 482.23 Condition of participation: Nursing services.

(b) (4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan.

(c) Standard: Preparation and administration of drugs.

(1) Drugs and biologicals must be prepared and administered in accordance with Federal and State laws, the orders of the practitioner or practitioners responsible for the patient's care as specified under Sec. 482.12(c), and accepted standards of practice.

(i) Drugs and biologicals may be prepared and administered on the orders of other practitioners not specified under Sec. 482.12(c) only if such practitioners are acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules, and regulations.

(ii) Drugs and biologicals may be prepared and administered on the orders contained within pre-printed and electronic standing orders, order sets, and protocols for patient orders only if such orders meet the requirements of Sec. 482.24(c)(3).

(2) All drugs and biologicals must be administered by, or under supervision of, nursing or other personnel in accordance with Federal and State laws and regulations, including applicable licensing requirements, and in accordance with the approved medical staff policies and procedures.

(3) With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders in accordance with State law and hospital policy, and who is responsible for the care of the patient as specified under Sec. 482.12(c).

New Conditions Of Participation For Hospitals (Continued.)

[Verbal Orders]

(i) If verbal orders are used, they are to be used infrequently.

(ii) When verbal orders are used, they must only be accepted by persons who are authorized to do so by hospital policy and procedures consistent with Federal and State law.

(iii) Orders for drugs and biologicals may be documented and signed by other practitioners not specified under Sec. 482.12(c) only if such practitioners are acting in accordance with State law, including scope-of-practice laws, hospital policies, and medical staff bylaws, rules and regulations.

(4) Blood transfusions and intravenous medications must be administered in accordance with State law and approved medical staff policies and procedures.

(5) There must be a hospital procedure for reporting transfusion reactions, adverse drug reactions, and errors in administration of drugs.

[Medications/Self-Administration]

(6) The hospital may allow a patient (or his or her caregiver/support person where appropriate) to self-administer both hospital-issued medications and the patient's own medications brought into the hospital, as defined and specified in the hospital's policies and procedures.

(i) If the hospital allows a patient to self-administer specific ***hospital-issued medications***, then the hospital must have policies and procedures in place to:

(A) Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration.

(B) Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s).

(C) Instruct the patient (or the patient's caregiver/support person where appropriate) in the safe and accurate administration of the specified medication(s).

(D) Address the security of the medication(s) for each patient.

(E) Document the administration of each medication, as reported by the patient (or the patient's caregiver/support person where appropriate), in the patient's medical record.

(ii) If the hospital allows a patient to self-administer ***his or her own specific medications brought into the hospital***, then the hospital must have policies and procedures in place to:

(A) Ensure that a practitioner responsible for the care of the patient has issued an order, consistent with hospital policy, permitting self-administration of medications the patient brought into the hospital.

(B) Assess the capacity of the patient (or the patient's caregiver/support person where appropriate) to self-administer the specified medication(s), and also determine if the patient (or the patient's caregiver/support person where appropriate) needs instruction in the safe and accurate administration of the specified medication(s).

(C) Identify the specified medication(s) and visually evaluate the medication(s) for integrity.

(D) Address the security of the medication(s) for each patient.

(E) Document the administration of each medication, as reported by the patient (or the patient's caregiver/support person where appropriate), in the patient's medical record.

Sec. 482.42 Condition of participation: Infection control.

(a) Standard: Organization and policies.

A person or persons must be designated as infection control officer or officers to develop and implement policies governing control of infections and communicable diseases. The infection control officer or officers must develop a system for identifying, reporting, investigating, and controlling infections and communicable diseases of patients and personnel.

(b)(1) Ensure that the hospital-wide quality assessment and performance improvement (QAPI) program and training programs address problems identified by the infection control officer or officers.

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Medication Error: Hospital Admits Liability, Patient Appeals Verdict.

The patient was brought to the E.R. for an allergic reaction to a bee sting.

The E.R. physician ordered sub q epinephrine which was successful at first but later a second dose was necessary.

The E.R. nurse gave the second dose of epinephrine IV rather than sub q.

The nurse stood by to monitor the patient's reaction. The patient immediately complained of pain in her head. Her heart rate jumped from 101 to 190 and her BP went from 136/55 to 205/129.

The E.R. physician was called in and sent the patient to the ICU. Supraventricular tachycardia, a reaction to the IV epinephrine, subsided after about one minute but the patient was kept in the ICU for eight hours before being sent home.

This medication error could have caused permanent damage to the heart and peripheral nervous system, but there was no evidence it did so in this case.

COURT OF APPEAL OF LOUISIANA
May 2, 2012

In the patient's lawsuit the hospital admitted that the E.R. nurse was negligent for giving the epinephrine IV. The jury had only to assess the damages.

The patient appealed the jury's verdict of $25,000 claiming the amount was unreasonably low. The Court of Appeal of Louisiana upheld the jury's verdict.

The nurse monitored the patient for a reaction and there was an appropriate response when the reaction occurred. The nurse and her employer never tried to hide the fact the nurse made a mistake or that the mistake caused painful and frightening consequences for the patient. However, the patient's own cardiologist and a consulting psychiatrist discounted the extensive long-term physical and emotional injuries the patient was claiming. **Langley v. American Legion Hosp., 2012 WL 1521520 (La. App., May 2, 2012).**

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For the Nursing Profession

Jury Duty: Malpractice Defense Verdict Thrown Out Over Nurse's Juror Misconduct.

The diabetic patient filed a malpractice lawsuit against the radiologist who read an x-ray ordered by his primary-care physician. The suit alleged the radiologist misread the image as normal and thereby delayed the patient's referral to an orthopedist for treatment of Charcot foot.

Home Health Nurse Served on the Jury

During jury selection at the beginning of the trial an LPN called up for jury duty was questioned by the judge and assured the judge that nothing in her nursing experience would bias her in favor of one side or the other. She had extensive experience with diabetic patients, she told the judge, but had never cared for anyone with Charcot foot. She promised not to substitute her own nursing experience and training in place of the testimony of the witnesses in the trial.

After all the testimony was in but before actual jury deliberations began the LPN was elected by the other members of the jury as jury foreperson.

After the jury ruled in favor of the radiologist the patient's lawyers were able to obtain a sworn affidavit from one of the jurors about the nurse's misconduct during jury deliberations.

During a trial those involved in the case and their lawyers are strictly forbidden from communicating with the jurors outside the courtroom.

After the trial, however, they are permitted to obtain feedback from the jurors as to the factors that influenced the jury's decision.

According to the fellow juror, after being chosen as jury foreperson the LPN took charge of the deliberations and eagerly shared her experiences and opinions as to the proper care of diabetic patients.

She was sure the patient must have had prior foot problems, must have had a podiatrist and must not have been following his podiatrist's directions as most diabetics do not follow their doctors' instructions. In her opinion, the problem with Charcot foot would have come about anyway regardless of any delay caused by the radiologist's mistake.

The Supreme Court of Oklahoma ordered a new trial for the patient's case on grounds it is prejudicial misconduct for a juror to violate his or her promises not to bring extraneous assumptions to the jury's attention or to override the testimony in the case. **Ledbetter v. Howard, __ P. 3d __, 2012 WL 1473418 (Okla., April 24, 2012).**

Patient's Fall: No Cane, Walker Or Assistance Offered To Unsteady Patient, No Expert Required.

The patient was admitted to the hospital's inpatient psychiatric unit for what was described in the court record as a recurring nervous condition.

The patient had difficulty standing and walking. Her husband, however, was told not to bring her walker or her cane with her to the hospital because the hospital would provide everything she needed, including those items.

Her psychiatrist, after admitting his patient, specifically informed the nurses the patient had difficulty standing.

That same evening just after she walked out of her hospital room to go to the dining room on the unit for supper she had to stand against the wall to keep from falling. While standing there she reportedly told the nurses she was about to fall, but the nurses did not offer her a wheelchair, walker, cane or assistance.

Expert testimony is not required on the question of whether to offer a cane to an unsteady elderly patient with obvious balance and mobility problems.

The nurses' decision not to provide the patient a cane or walker or other assistance did not require a medical assessment, physician's orders, specialized nursing clinical judgment or other specialized skill.

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The patient fell and was injured.

After the patient sued, the hospital asked for dismissal on the grounds that there was no paperwork in the court file that the patient's lawyers had had the medical records reviewed by an expert and obtained a commitment from the expert to testify on the patient's behalf as required by North Carolina law for healthcare malpractice cases.

The Court of Appeals of North Carolina ruled the case should not be dismissed on that basis.

According to the Court, no expert opinion is required to establish that an elderly person who uses a cane or walker for balance problems will most likely fall and be injured if not provided with a cane, walker, wheelchair or assistance from her caregivers. **Horsley v. Halifax Reg. Hosp., __ S.E. 2d __, 2012 WL 1512507 (N.C. App., May 1, 2012).**