Discrimination: Nurse Did Not Follow Procedure, Case Dismissed.

A minority nurse was terminated after warnings, counseling, a performance improvement plan and progressive discipline did not resolve her job performance issues.

The nurse was repeatedly counseled and was given a performance improvement plan, but that did not correct her behavior.

The hospital was within its rights to require nurses to sign out before leaving the cardiac cath unit, to insure there was always sufficient nursing coverage present.

UNITED STATES DISTRICT COURT
NEW YORK
November 29, 2011

The nurse sued for discrimination, but the US District Court for the Western District of New York dismissed her case.

There was nothing discriminatory in the fact that other employees, non-minorities, were not required to sign out when leaving the cath lab. They were not patient-care nurses.

The Court said it is legitimate for a hospital to institute and enforce procedures to insure there is always adequate nursing coverage on the cardiac cath unit.

The nurse's allegations her supervisors were culturally disrespectful when they communicated her negative performance appraisals to her was not sufficient to make out a case of a racially hostile work environment, the Court ruled.

A racially hostile work environment, the courts have ruled, arises only when there is racially discriminatory intimidation, ridicule or insult so severe or pervasive as to alter the conditions of employment and create an abusive working environment. **Coley-Allen v. Strong Health, 2011 WL 5977792 (W.D.N.Y., November 29, 2011).**

Lumbar Puncture: Patient Given Contraindicated Drugs, Nurses Ruled Partly Responsible.

The patient's nurses were negligent.

The nurses did not stop two medications, namely Lovenox and aspirin, that are known to cause bleeding complications in a lumbar puncture.

The testimony was conflicting whether the physician gave orders for the nurses to discontinue these medications.

If the physician ordered these medications stopped, and the nurses failed to stop them, that is clear-cut negligence.

If the physician did not order them to stop the medications, the nurses should have realized the meds needed to be stopped and contacted the physician and, if necessary, gone to their nursing supervisor.

The nurses apparently did not appreciate the potential side effects of the medications they were giving before and after a lumbar puncture.

The nurses failed to identify the need for an MRI after signs of complications began to appear.

The nurses failed to recognize the catastrophic neurological changes the patient was having.

COURT OF APPEALS OF TEXAS
December 12, 2011

The patient came to the E.R. in the early a.m. hours with symptoms of a severe headache and a stiff neck. The physician ordered a number of tests to try to find out what was going on.

The physician ordered aspirin and Lovenox, blood thinners, twice daily. The first dose was given at noon and the next at midnight. The physician also ordered a lumbar puncture.

The lumbar puncture was scheduled for mid-afternoon the next day. The patient got his aspirin and Lovenox at noon before the procedure and again at midnight afterward.

The following day he began to develop signs and symptoms of a spinal hematoma, back pain, loss of feeling in his legs and inability to urinate. The neurologist who did the lumbar puncture was contacted and ordered an immediate spinal MRI. Although ordered at 6:00 a.m. the MRI was not done until 3:00 p.m. the next day, thirty-three hours after being ordered.

The patient never recovered from the spinal hematoma despite a neurosurgical intervention at a tertiary care facility and is now a paraplegic.

Nurses Ruled Negligent

The Court of Appeals of Texas ruled that the patient's nurses were negligent. They should have known that anti-coagulant medication is contraindicated in conjunction with a lumbar puncture due to the grave risk of the very same complications this patient actually experienced.

The case was complicated legally by the fact the nurses, who were sued individually along with the hospital and the treating physicians, settled with the patient before the case went to trial.

The Court ruled that the jury in the trial should have been instructed to weigh the extent the nurses' negligence contributed to the unfortunate outcome so that the physicians and the hospital would only have to pay their proportionate shares. The jury found the physicians in total 85% responsible, which may not have been exactly correct, so a new trial was ordered. **Janga v. Colombrito, __ S.W. 3d __, 2011 WL 6146197 (Tex. App., December 12, 2011).**