HCFA Regs On Use Of Restraint And Seclusion – Inpatient Psych (Continued).

terventions, must evaluate the resident's well-being immediately after the restraint is removed.

Sec. 483.364 Monitoring of the resident in and immediately after seclusion.

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(c) If the emergency safety situation continues beyond the time limit of the order for the use of seclusion, a registered nurse or other licensed staff, such as a licensed practical nurse, must immediately contact the ordering physician or other licensed practitioner permitted by the state and the facility to order restraint or seclusion to receive further instructions.

(d) A physician, or other licensed practitioner permitted by the state and the facility to evaluate the resident's well-being and trained in the use of emergency safety interventions, must evaluate the resident's well-being immediately after the resident is removed from seclusion.

Sec. 483.374 Facility reporting.

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(c) Reporting of deaths. In addition to the reporting requirements contained in paragraph (b) of this section, facilities must report the death of any resident to the Health Care Financing Administration (HCFA) regional office.

(1) Staff must report the death of any resident to the HCFA regional office by no later than close of business the next business day after the resident's death.

(2) Staff must document in the resident's record that the death was reported to the HCFA regional office.

FEDERAL REGISTER, May 22, 2001
Pages 28110 – 28117.

Needle Broken Off During Surgery: Court Faults Perioperative Nurses, But Finds No Fraudulent Concealment.

Nurses and physicians have the legal duty not to injure their patients through negligence.

And if a patient is injured, the patient's nurses and doctors cannot try to deny, conceal or minimize that the injury occurred, its seriousness or the sequelae to be expected.

If nurses or doctors try to hide things from a patient it can be a separate and distinct basis for a lawsuit and it can lead to punitive damages being awarded.

COURT OF APPEALS OF GEORGIA, 2001.

During a young child's tonsillectomy, as the surgeon was suturing a bleeding blood vessel the tip of the needle broke off inside the tonsil fossa. The bleeding only worsened when he tried to probe for the needle tip, so he decided not to retrieve it. He got an x-ray, determined the needle fragment was not a threat to the patient and finished the procedure.

Perioperative Nursing Negligence

According to the Court of Appeals of Georgia, the root cause was the operating room nurses handing the surgeon a thinner needle than the size he called for.

The jury awarded $22,500 as compensation for the child having to undergo a second procedure to remove the needle tip after complications arose.

The award went only against the hospital, the nurses' employer. The surgeon was ruled not negligent.

No Fraudulent Concealment
No Punitive Damages

After the procedure, the surgeon and the hospital's director of perioperative services, a nurse, sat down with the parents. They admitted a small portion of a needle broke off and was left in the child's throat. They said this kind of thing happens all the time. They said it was not a problem and would never have to be removed. That turned out not to be true.

The surgeon estimated in his operative report the needle tip was .25 inch (0.635 cm). When removed it actually measured 1.6 cm, the court said.

The operating room nurses made no mention in their perioperative charting that a needle had broken off inside the patient's throat, that an x-ray was obtained, that the surgeon decided to leave it inside or that a different needle than the one requested had been handed to the surgeon.

The court stated in general terms that a patient can sue a nurse or a physician who fraudulently misinforms the patient or tries to conceal the fact that a mistake has been made. Healthcare professionals have a legal duty not to deceive their patients by trying to cover up their mistakes. The special relationship of trust with their patients makes such conduct wholly inappropriate.

And the civil law, as a general rule, punishes intentional misconduct with punitive damages above and beyond the sum that is reasonable to compensate the patient for the patient's actual losses.

In this case, however, the court ruled there was no active misrepresentation or passive fraudulent concealment, even though what the family was told turned out not to be true exactly.

The court upheld the hospital's obligation to pay compensation for the nurses' negligence in selecting the wrong needle, but threw out the jury's award of punitive damages as contrary to the evidence. **Kodadek v. Lieberman, 545 S.E. 2d 25 (Ga. App., 2001).**