Neglect Of A Resident: Nursing Judgment Not To Give PRN Med Is Not Misconduct, Court Says.

A licensed practical nurse operated an assisted living facility serving six residents. A man was admitted to the facility who was seventy-six years-old and suffered from Parkinson's and dementia that was probably Alzheimer's.

According to the court record, he had been taking four medications at home, one for Parkinson's, one for depression, one to help him sleep, and the medication in question, Xanax, a sedative.

The man's wife became dissatisfied with the care he was getting and complained to the state's Long-Term Care Ombudsman. An investigator visited the facility, found he had not been getting his Xanax and wrote up the facility on charges of neglect.

An administrative law judge ruled it was neglect not giving him the Xanax, even though there was no evidence he suffered any ill effect from not receiving it.

Court Says No Neglect

The District Court of Appeal of Florida threw out the administrative law judge's decision and validated the nurse. The court ruled there was no neglect as neglect is defined by law.

The mere fact the Xanax had been prescribed for the resident was insufficient. The nurse had received no physician's orders stating why, when or how often it was to be given.

The court said no reasonable person could see the Xanax as essential for the resident's well-being or conclude that not giving it did or could cause physical or psychological injury.

Nursing Judgment Upheld

In fact the nurse was familiar with Xanax and its clinical indications and believed in her best nursing judgment there was no reason to give it during the eight days in question from his admission until the investigator visited the facility.

The court supported the nurse for applying her best nursing judgment. **C.B. v. Dept. of Children & Family Services, 763 So. 2d 356 (Fla. App., 2000).**

It was reasonable for the nurse to use her common sense and her training as a nurse to decide whether the Xanax was necessary.

The resident was wheelchair-bound and drowsy most of the time. The nurse saw no need to give the resident a sedative.

The Xanax was an at-home med prescribed before the resident was admitted to the assisted living facility and was given to him by his wife when he first got there. There were no physician's orders for the nurse when and when not to give it.

Neglect means the failure or omission by a caregiver to provide care, supervision and services necessary to maintain the physical and mental health of a disabled or elderly person, including food, clothing, medicine, shelter, supervision and medical services that a reasonable person would consider essential to the well-being of a disabled adult or elderly person.

Neglect can be one careless incident, if it causes or could have caused serious physical or psychological harm to a resident.

DISTRICT COURT OF APPEAL OF FLORIDA, 2000.

Nursing Home Resident Falls: Court Says She Was To Be Restrained.

An elderly woman was admitted to a nursing home directly from the hospital where she had had surgery for hip and wrist fractures.

The referral form from the hospital authorized a vest restraint prn for confusion. The care plan that came with her from the hospital stated she was alert but "pleasantly confused" and was to have a vest restraint at all times due to her risk of attempting to walk and falling.

The nursing home staff left her unrestrained and unattended in her room in a wheelchair. She was found on the floor three hours after admission with a new fracture to the same hip.

To sue the nursing home the resident's lawyers did not need to file a report from an expert witness.

They were not suing for professional malpractice. They did not need to sue for malpractice. It was plain ordinary negligence not to restrain this resident under these circumstances.

SUPREME COURT OF MINNESOTA, 2000.

The Supreme Court of Minnesota ruled there were grounds to sue.

The discharge care plan from the hospital had the force and effect of a physician's orders. According to the court, the nursing home staff had no room to use their professional judgment or discretion whether or not to restrain this resident. The vest restraint was mandatory under the circumstances. **Tousingnant v. St. Louis County, 615 N.W. 2d 53 (Minn., 2000).**