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Restraints/Failure To Answer Call Bell: Large Verdict For Nursing Negligence.

The eighty-six year-old patient was admitted to the hospital for heart problems. He was experiencing confusion and disorientation.

A nurse observed him trying to get out of his hospital bed without assistance. After his third try he was moved to a room on the telemetry floor near the nurses' station. He was placed in a Posey vest.

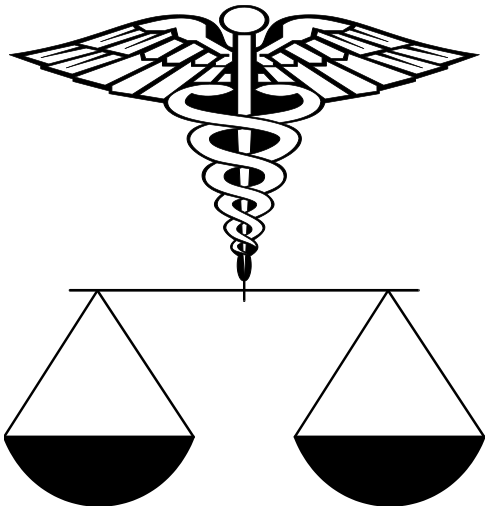
On a telemetry unit a technician watches electronic monitors showing each patient's vital signs and cardiac readouts. On this unit the electronic equipment also noted and recorded call bells activated by the patient requesting help from the nursing staff.

During the 11:00 p.m. hour the patient rang four times. At 12:01 a.m. the monitor indicated a ventricular fibrillation so the technician sent a nurse to the room. The nurse found the patient on the floor strangled by his Posey vest. A code was called but he died.

Physician's Order for Restraints

The court stated it would be a clear violation of the law and a breach of the standard of care for nurses to use a Posey vest without a physician's order.

A representative of the company that manufactures the vests pointed to the warnings on the packages and the labels on the vests themselves.



The nurses on duty testified that failing to respond to four call bells requesting assistance over a one-hour interval, with the patient in a Posey vest, is below the legal standard of care for nurses.

Putting a patient in a Posey vest without a physician's order violates Federal law and is below the legal standard of care for nurses.

SUPREME COURT OF TEXAS
April 24, 2003

Call Bell Not Answered

The court said it is below the legal standard of care for nurses not to respond promptly to a patient's call bell. The nurse's legal duty is especially acute with a confused, disoriented patient who is in a vest restraint because he tries to get out of bed without assistance. A nurse cannot assume a soft cloth restraint will keep such a patient in bed, but must anticipate the patient might try to get up anyway and get caught up in the restraint.

Order Not Transcribed

A nurse testified in court there was a physician's order for the Posey but she had not transcribed it before the patient died. The physician testified he approved the restraint, although he did not say exactly when he ordered it.

Nevertheless the judge instructed the jury to consider only the nurse's statement in the hospital incident report that there was no order for the Posey, which would be a violation of Federal and state law and a serious breach of the standard of care for nurses.

$1,369,000 Verdict Thrown Out

The Supreme Court of Texas threw out the verdict. It was wrong for the jury to consider only the nurse's statement and not her testimony.

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Restraints/Failure To Answer Call Bell: Large Verdict For Nursing Negligence.

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The hospital had interviewed and obtained written statements from the nurses on duty and from the telemetry technician.

When the family sued for wrongful death their lawyer immediately asked for copies of the written statements. The hospital refused to turn them over, citing attorney-client privilege.

The judge ordered the statements turned over to the family's attorney. The hospital continued to take a stand on the principle of attorney-client privilege, but then gave in a few weeks before trial and turned over the statements.

As punishment the court instructed the jury to take everything stated in the nurses' and technician's statements as facts established conclusively.

As a general rule the judge has considerable latitude to decide on an appropriate punishment for one party or the other for refusing to obey a court order, whether the party is taking a stand on principle or just being difficult.

However, the lower-court judge in this case was plainly too harsh, in the Supreme Court's judgment. In full fairness a jury is not obligated to accept a witness's prior statement over the witness's testimony in court or the testimony over the statement. Deciding what to believe and what not to believe is traditionally the sacred province of the jury in civil cases.

Witness Statements Available To Patient's Family's Attorneys

Contemporaneous incident reports containing raw factual data are different from peer review, quality review and attorney-client communications.

Incident reports and straightforward factual statements of eyewitnesses do not reflect the deliberations of the institution's quality review officials or the strategic thinking of legal counsel and can get into the other side's hands if the judge believes there is no other way for the other side to get the same information.. **Spohn Hospital v. Mayer, 46 Tex. Sup. Ct. J. 604, __ S.W. 3d __ , 2003 WL 1923002 (Tex., April 24, 2003).**

Discovery sanctions that are so severe as to inhibit presentation of the merits of the case should be reserved only for instances of bad faith or callous irresponsibility.

The trial judge abused the court's discretion.

The judge instructed the jury to take the substance of the witness statements as established facts, and the jury was not at liberty to disbelieve them.

In addition, the judge misstated what one of the nurses said on the issue whether there was no physician's order or it was just not transcribed.

SUPREME COURT OF TEXAS
April 24, 2003

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EMTALA: E.R. Patient Smelled Of Alcohol, No CT, No Liability.

The patient was brought in to the emergency room by ambulance at 1:36 a.m. His girlfriend found him on the ground outside the bar where they had gone and called for the ambulance.

At the hospital the patient was seen by a nurse and physician. A small laceration on his left temple was sutured. The nurse noted he was alert and awake. The physician noted his pupils were equal and reactive. No abnormal neuro signs were noted except for lethargy. He was released without a CT scan. Later that day he was treated at another hospital for right frontal and temporal lobe hematomas.

In EMTALA cases the courts do not second-guess the professional judgment of nurses and doctors who screen and treat patients in the emergency room.

The question is whether the patient was given the same care and attention a patient would get with the same history, signs and symptoms.

COURT OF APPEAL OF LOUISIANA
April 23, 2003

The Court of Appeal of Louisiana found no violation of the US Emergency Medical Treatment and Active Labor Act (EMTALA). The hospital's nursing and quality assurance directors testified any patient at their hospital with an otherwise normal neuro assessment who was intoxicated would not get a CT scan just because he was somewhat lethargic. He got the same screening examination as anyone else at the hospital in the same situation. **Scott v. Dauterive Hosp. Corp., __ So. 2d __, 2003 WL 1916273 (La. App., April 23, 2003).**