LEGAL EAGLE EYE NEWSLETTER
For the Nursing Profession

Neighbor Struck By Motorized Wheel Chair: Court Says Home Health Aide Not To Blame.

A neighbor who lived in the same apartment building where an MS patient lived was struck and killed by the patient driving his motorized wheelchair. The New York Supreme Court, Appellate Division, did not elaborate on the injuries or how the incident occurred.

The deceased's family sued the patient's home health agency, his home health aide and the landlord. The lawsuit was dismissed.

A home health agency and its employees have the obligation to care for their patients. But that is all, the court ruled. They have no right to control or means to control their patients' behavior and no responsibility for how a patient operates a power wheelchair. The landlord was let out of the case because there was no prior knowledge that the patient posed a danger. **Leifer-Woods v. Edwards, 722 N.Y.S.2d 43 (N.Y. App., 2001).**

Defective Surgical Hardware: Hospital Has No Obligation To Know About Unknown Defects.

In 1992 a physician used pedicle screws from a certain manufacturer during spinal fusion surgery at the hospital. The physician was not a hospital employee but was in private practice with surgical privileges at the hospital.

In 1995 it became known that these pedicle screws were believed to be defective. The patient sued the manufacturer, the surgeon and the hospital. The Court of Appeal of Louisiana let the hospital walk away from the lawsuit.

The hospital's risk manager testified that the hospital was not aware of publicized concerns about the hardware until 1995.

The court ruled a hospital is not obligated somehow to ascertain that items used in surgery are defective before the suspected defect is discovered and becomes public knowledge. **Coleman v. Acromed Corporation, 779 So. 2d 1060 (La. App., 2001).**

Surgical Pad Not An Item To Be Counted: Court Says Hospital Liable Anyway When Left Inside.

The patient had open-heart surgery to repair an aortic septal defect. For this procedure, according to the Supreme Court of Oklahoma, it is accepted procedure to place a phrenic nerve pad beneath the heart while it is stopped to prevent damage to the underlying nerve and to insulate the iced heart from the patient's body heat.

The court indicated there is a cord attached to the pad that is meant to extend outside the incision to remind the surgical team to remove the pad, but surgeons commonly cut the cord off to keep it out of the way.

In this case the phrenic nerve pad was left inside the patient, leading to complications and a relatively minor second surgery to retrieve the pad. The patient sued.

The hospital's printed surgery count form did not list a phrenic nerve pad. It was not counted and it was left inside the patient. The members of the surgical team were negligent.

It does not matter if the count was correct of the items that were counted.

It does not matter if other hospitals do not count this pad or if AORN guidelines do not consider this pad an item to be counted.

SUPREME COURT OF OKLAHOMA, 2000.

The court ruled it is no defense, when a foreign item is not removed that should be removed, that the item was not on the hospital's list of items to be counted during surgery.

The court went on to discount expert witness testimony that other hospitals routinely do not include phrenic nerve pads on their count lists and that the widely-recognized guidelines of the Association of Operating Room Nurses (AORN) do not include a phrenic nerve pad among the items to be counted.

The court did not hold the surgical team negligent automatically, but gave them the right to explain. However, the team had no explanation except being intently focused on the procedure itself, which did not satisfy the court. **Franklin v. Toal, 19 P. 3d 834 (Okla., 2000).**