

# Case Study Part 2 - July 2015

written by Nancy Brent | May 26, 2016

## **Avoiding Liability Bulletin - July 2015**

[You may recall that one of June's bulletins](#) was a case study about Mary Clark, her difficult personal life, and the death of one of the residents at the Delta Nursing Home and Rehabilitation Center where she worked. At the end of the case study, questions were posed for you to consider.

Let's assume the deceased patient's niece decides to file a wrongful death suit against the Center and Mary, naming Mary as a defendant.

The attorney for Mr. Romero's niece has reviewed the medical record of Mr. Romero in order to determine how Mr. Romero's care was before the incident that resulted in his death. The attorney has also reviewed the documentation about the actual incident. A nurse expert hired by the attorney also reviewed the entire record.

The nurse expert's opinion is that Mary Clark was professionally negligent in that she was assigned to Mr. Romero that day and apparently failed to promptly answer Mr. Romero's call bell for a nurse. Although Mary's documentation in the record about the incident did not state the fact that she failed to promptly answer Mr. Romero's bell, this is what the nurse expert believes happened.

The attorney takes the depositions (statements under oath) of Mary Clark, the patient's roommate, Mr. Johnson, all the other nursing staff who responded when she pushed the emergency bell in the room, Mary's nurse manager, and the paramedics who responded to the 911 call from the Center.

During Mary's deposition she testified at length about the stress she was under due to her home situation and the fact that she was working extra shifts in order to get enough money to challenge the current custody arrangements of her children with her ex-husband. She admitted under oath that she was fatigued, not sleeping, and as a result, some of the patient's "bothered her" with their demands. She also admitted that she did not answer Mr. Romero's call bell right away on the day of his death, adding he often used it to get attention rather than for a real need.

The nurse expert's deposition clearly supported the fact that Mary Clark breached her overall standard of care to Mr. Romero and her standards of practice in that she had a duty to respond to his call bell, failed to do so, and as a result, Mr. Romero's attempt to get out of bed himself resulted in his head getting caught between two of the bedside rails and his death. The autopsy report, which was entered into evidence during trial, ruled Mr. Romero's death an accident.

The nurse expert who testified for Mary and the Center testified that Mr. Romero's head getting caught in the side rails while attempting to get out of bed was the proximate cause of his death. In addition,

she testified that the side rails on the bed were a danger to any patient whether or not the patient was attempting to get out of bed because of the narrow spaces between the slats of the side rails.

Based on this testimony and that of the other witnesses, the attorney decides to depose the ex-husband. The ex-husband details the behavior of his ex-wife he observed and experienced during the period surrounding the incident with Mr. Romero, none of which was helpful to Mary. He described her as short-tempered, tired, and that she complained often about work and the “demanding patients”.

Mary’s attorney (she had her own professional liability insurance policy and therefore her own attorney) and the attorney from the Center argued that it was the patient who caused his own death by not waiting for a nurse to answer his call bell, however long it took for a nurse to respond. After all, the attorneys argued, he had been told time and time again not to get out of bed himself.

Mary’s attorney also elicited testimony from her nurse manager and staff nurse colleagues that although Mary seemed more fatigued due to her additional shifts at work and was stressed due to her personal situation, she was a good nurse who cared about her patients.

The case went to trial and the jury returned a verdict in favor of the niece and against Mary and the Center for a large amount of money. Mary’s portion of the verdict against her was paid by her insurance carrier. As required, that payment was reported to the National Practitioner Data Bank.

The case study underscores many points. When a patient is injured or dies due to alleged nursing negligence, aspects of the nurse’s nursing practice, personal life, and any other relevant facts can be introduced into evidence to support a breach of the nurse’s standard of practice and overall standard of care. The plaintiff’s attorney must prove the alleged negligence/wrongful death by a preponderance of the evidence, which in this situation, was fairly easy to do.

A second emphasis in the case study is who can be called as a witness. As you saw above, many were deposed. These individuals are fact witnesses, meaning that they have knowledge about the issues in the case through direct observation or participation in the matter at issue. Mr. Johnson testimony was critical, for example, because he directly observed what went on in the room prior to Mr. Romero’s demise and afterward when Mary and the other nursing staff responded to the call bell.

The nurse expert witness’ testimony was also crucial because both were qualified due to education, experience, and training to provide a specialized nursing opinion about the nursing care of Mr. Romero and the duties Mary had in that nurse-patient relationship. Remember, any case alleging professional negligence/wrongful death by a nurse must include nurse expert opinions.

This case study was based on an actual incident that took place several years ago. The nurse involved and the place she worked were not sued, since the deceased had no family. The nurse was lucky in that regard, but a patient still died, a death that might have been avoided had the nurse gone into that room when she initially heard the call bell.

The nurse was reported to the state board of nursing, however, and was disciplined for unprofessional conduct .

If you have any comments you'd like to share about the case study, I encourage you to do so and I look forward to responding to them.

**THIS BULLETIN IS FOR EDUCATIONAL PURPOSES ONLY AND IS NOT TO BE TAKEN AS SPECIFIC LEGAL OR OTHER ADVICE BY THE READER. IF LEGAL OR OTHER ADVICE IS NEEDED, THE READER IS ENCOURAGED TO SEEK ADVICE FROM A COMPETENT PROFESSIONAL.**