IN THE SUPERIOR COURT OF THE STATE OF DELAWARE
IN AND FOR NEW CASTLE COUNTY

MADHU JAIN,	)	
	)	
Appellant,	)	
	)	
v.	)	
	)	C.A. No. N10A-02-001 JAP
DELAWARE DEPARTMENT	)	
OF HEALTH AND SOCIAL	)	
SERVICES,	)	
	)	
Appellee.	)	

Submitted: July 26, 2010
Decided: October 29, 2010

Petition for Review of a Decision of the
Division of Long Term Care Residents Protection
Decision ***REVERSED***

OPINION

Appearances:

"J" Jackson Shrum, Esquire, Wilmington, Delaware
Attorney for Appellant Madhu Jain

Peter S. Feliceangeli, Deputy Attorney General, Wilmington, Delaware
Attorney for Appellee Delaware Department of Health and Social Services

JOHN A. PARKINS, JR., JUDGE

Introduction

Appellant Madhu Jain, ("Jain"), has timely petitioned this Court for review of a decision of the hearing officer of the Division of Long Term Care Residents Protection, ("DLTCRP"), dated January 14, 2010, requiring Jain to be listed on the Adult Abuse Registry for a finding of Substantiated Abuse.

Jain requested a hearing after the DLTCRP informed her that it intended to place her name on the Adult Abuse Registry for five years. After a fair hearing held on December 17, 2009, the hearing officer rendered a decision on January 14, 2010, finding neglect but reducing the length of time Jain's name would remain on the Adult Abuse Registry from five to three years.

Factual and Procedural Background

Jain is a registered nurse who had been working at the Delaware Psychiatric Center for fifteen years.[1] She has never previously been accused of patient abuse or neglect.[2] On the date in question, she was on duty and responsible for operations of the K3 ward.[3] The K3 ward is a mixed-gender ward where patients exhibit aggressive behavior on a regular basis.[4] Jain,

[1] Decision of Hearing Officer, p. 6.

[2] Decision of Hearing Officer, p. 6.

[3] Decision of Hearing Officer, p. 6.

[4] Decision of Hearing Officer, p. 5.

having been assaulted by aggressive patients on numerous previous occasions, was normally cautious when approaching patients.[5]

On April 4, 2009, a patient who had a history of lying on the floor and being aggressive was found lying in the hallway of the K3 ward.[6] The video breakdown list provided with the record states that the patient exited her room, lay down in the hallway, raised her head several times, and rolled over to her side. Hearing a commotion, Jain left the nurse's station and came upon the patient who was face down on the floor, eyes closed, soaked in urine, and breathing.[7] Jain called out to the patient but she did not respond.[8] Jain, being familiar with the patient's history and seeing that the patient was breathing, believed that the patient was suffering from a psychiatric episode and not a medical emergency.[9] Consequently, she did not touch the patient or perform a physical assessment at that time.[10] Instead, she looked around to see who was nearby to help her bathe the patient and change the patient's clothing, but she

[5] Decision of Hearing Officer, p. 7.

[6] Decision of Hearing Officer, p. 6, 7.

[7] Decision of Hearing Officer, p. 7.

[8] Decision of Hearing Officer, p. 7.

[9] Decision of Hearing Officer, p. 2, 6-7.

[10] Decision of Hearing Officer, p. 2, 6-7.

saw no staff members in the vicinity.[11] On that particular day, the facility was short-staffed. So, Jain left the patient and went to find someone to assist her.[12] (Jain is a small woman and required assistance to attend to the patient's needs.[13]) Ralph Coverdale, a nurse assistant, testified that he also saw the patient breathing while she was lying on the floor and that she was still breathing after Jain had walked away.[14]

Approximately four minutes after Jain left to seek help for the patient, she was informed by a staff member that the patient had "gone bad."[15] Jain, along with two other nurses, Marie Keller and Clifford Truitt, ran to the patient to find her not breathing.[16] They immediately began emergency resuscitation procedures.[17]

At the hearing, due to her belief that the patient was having a psychiatric episode, Jain admitted to being concerned for her personal safety when initially

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[11] Hearing Transcript, p. 101-102.

[12] Decision of Hearing Officer, p. 7.

[13] Decision of Hearing Officer, p. 7; Appellant's Opening Brief, p. 4.

[14] Decision of Hearing Officer, p. 2; Hearing Transcript, p. 36.

[15] Decision of Hearing Officer, p. 8.

[16] Decision of Hearing Officer, p. 8.

[17] Decision of Hearing Officer, p. 8.

approaching the patient.[18] However, the hearing officer's decision also contained testimony from Truitt that it is not uncommon for patients at the Delaware Psychiatric Center to lie on the floor and urinate and defecate on themselves.[19] Coverdale corroborated this statement by testifying that it was common for psychiatric patients to lie on the floor and that many were unpredictable.[20] Truitt further stated that there is a risk of aggression in a situation where a patient is lying on the floor and that the first method of assessing the patient's status would be to see if the patient is breathing.[21] Truitt and Jain also testified that a psychiatric patient's failure to respond to a verbal command is not unusual.[22]

Testimony from Earl Robinson, a registered nurse of 21 years and nurse consultant at the Delaware Psychiatric Center, provided that the Center promotes dignity and does not allow patients to lie on the floor.[23] He indicated that, although no written policy exists, if any patient is found on the floor, a

[18] Decision of Hearing Officer, p. 8.

[19] Decision of Hearing Officer, p. 6.

[20] Decision of Hearing Officer, p. 2.

[21] Decision of Hearing Officer, p. 6.

[22] Decision of Hearing Officer, p. 6, 8.

[23] Decision of Hearing Officer, p. 4.

nurse is expected to encourage the patient to sit in a chair.[24] However, Robinson does not currently work with patients.[25] But, he did testify that if a patient lying on the floor did not respond to attempts at verbal interaction, "good nursing standards would require the nurse to provide further assessment" including checking to see if the patient is breathing.[26] Jain did this.[27] Robinson further opined that such an assessment would require touching the patient, which Jain did not initially do.[28] However, Robinson also testified that there was no written policy that states that touching the patient in such a situation is required.[29]

From the evidence, the hearing officer determined that Jain had violated the patient's safety needs by placing her own safety before the patient's, thus, constituting a finding of neglect. The hearing officer further found that by walking away from the patient without further assessment Jain breached the standard of care owed to the patient.

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[24] Decision of Hearing Officer, p. 4.

[25] Decision of Hearing Officer, p. 4.

[26] Decision of Hearing Officer, p. 4.

[27] Decision of Hearing Officer, p. 7.

[28] Decision of Hearing Officer, p. 4.

[29] Hearing Transcript, p. 80.

Contentions of the Parties

Jain asserts that her actions did not constitute neglect and that the decision of the hearing officer should be overturned because it is legally erroneous and unsupported by substantial evidence. The DLTCRP contends that Jain failed to assess the patient properly thereby constituting neglect.

Standard of Review

A final decision of a hearing officer of the Department of Health and Social Services may be appealed to the Superior Court.[30] This Court reviews a hearing officer's decision to determine if substantial evidence exists in the record to support the findings of fact and to determine if there was error as to the application of the law.[31] "Substantial evidence means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion."[32] Any questions of law arising from the hearing officer's decision are reviewed *de novo*.[33] "If the record supports the hearing officer's findings,

[30] 11 *Del. C*. § 8564.

[31] *Pioneer House Carelink v. Div. of Long Term Care Resident's Prot*., 2007 WL 4181670, *5 (Del. Super. Nov. 5, 2007).

[32] *Breeding v. Contractors-One-Inc.*, 549 A.2d 1102, 1104 (Del. 1988); *Pioneer House Carelink*, 2007 WL 4181670 at *5.

[33] *Pioneer House Carelink,* 2007 WL 4181670 at *5.

the Court should accept those findings even though, acting independently, the Court might reach a different conclusion."[34]

Discussion

Neglect is the "lack of attention to physical needs of the patient . . . including, but not limited to toileting, bathing, meals and safety."[35] Such neglect can be demonstrated by breaching the standard of care, violating a policy, or "any act or course of conduct that a fact-finder determines to be a lack of attention to a [patient's] physical needs."[36] However, where no testimony is provided that a facility's protocol, a facility's written policy or procedures, or procedures created by the Department of Health and Social Services were violated, it is difficult for a court to conclude that neglect has occurred.[37] And, "[w]hile the Court is not allowed to substitute its judgment for that found by the hearing officer simply because the Court disagrees with the conclusion, it must be able to find something in the record to support a finding that [a caregiver] engaged in a course of conduct which equated to neglect."[38]

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[34] *Arege v. State*, 2006 WL 2578265, *1 (Del. Super. Aug. 30, 2006).

[35] 16 *Del. C.* § 1131(9)(a); *Arege*, 2006 WL 2578265 at *1.

[36] *Arege*, 2006 WL 2578265 at *1.

[37] *See Arege*, 2006 WL 2578265 at *2.

[38] *Arege*, 2006 WL 2578265 at *2.

In *Arege v. State*, an elderly group home resident stopped breathing, and the staff member, a counselor, instead of calling 911 called a program director for guidance.[39] Only after calling the program director did the staff member call 911.[40] Furthermore, the staff member in *Arege* did not begin emergency resuscitation until told to do so by 911 dispatchers.[41] After attempts at resuscitation by paramedics, the elderly resident died.[42] The hearing officer in *Arege* upheld a finding of neglect and determined that the staff member's name should be placed on the Adult Abuse Registry for three years.[43] However, the Court reversed the decision of the hearing officer due to the paucity of evidence and the fact that the evidence failed to show how the staff member had either violated an established standard of care or neglected the needs of the elderly resident.[44]

Similarly, in the matter before the Court, little evidence specifically demonstrates how Jain neglected the needs of the patient or violated an established standard of care. While it is true that more testimony was brought

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[39] 2006 WL 2578265 at *1.

[40] *Arege*, 2006 WL 2578265 at *1.

[41] *Arege*, 2006 WL 2578265 at *1.

[42] *Arege*, 2006 WL 2578265 at *1.

[43] *Arege*, 2006 WL 2578265 at *1.

[44] *Arege*, 2006 WL 2578265 at *2.

forth in this matter than was provided in *Arege*, that testimony still does not demonstrate neglect to the Court's satisfaction.

Here, Jain made an assessment that the patient while on the floor was breathing and not having a medical emergency before she walked away to get help. And, even though testimony was heard from Robinson that a patient on the floor who was not responding to verbal encouragement should not be left on the floor but should be further assessed, Robinson further stated that part of that further assessment would be to check for breathing. Robinson also stated that an assessment would require touching the patient but he provided no established standard of care or facility policy or procedure to substantiate his claim that touching was required. What we have here is one nurse's judgment call pitted against a second nurse's opinion. And, this second nurse was not at the scene.

Furthermore, Jain was not leaving or ignoring the patient's needs but was going for help after her assessment that the patient was having a psychiatric episode. Based on the evidence, such an action on Jain's part was reasonable. To find neglect in a case where such a close call is involved is not supported by the evidence.

Moreover, while evidence does exist in the record, by way of Jain's admission, to support the fact that Jain was concerned for her own safety, no evidence supports the notion that she put her own safety before the patient's

welfare. Indeed, Jain testified (and this testimony appears to be unrebutted) that because of her small size, she needed assistance in lifting the patient and left to look for that assistance.

Accordingly, the decision of the hearing officer of the Division of Long Term Care Residents Protection is ***REVERSED*** and Jain's name is removed from the Adult Abuse Registry**.**

IT IS SO ORDERED.

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Judge John A. Parkins, Jr.