AV Dialysis Fistula: Hospital Not Liable For Accidental Exsanguination.

The patient had three episodes of abnormal bleeding from her AV dialysis fistula in her forearm. She was hospitalized for evaluation each time. After the third incident her physicians decided to rest the fistula for at least a month and to gain access for her dialysis through a temporary dual lumen catheter into her right internal jugular vein in her upper chest.

While at home alone two weeks later her AV fistula began to bleed. Being alone and significantly disabled, the patient was not able to do anything but bleed to death sitting in her wheelchair.

The family filed suit against the hospital which treated her three AV fistula bleeding incidents.

There was nothing in the clinical records to fault the decisions of the nursing and medical staffs of the hospital or the dialysis clinic, that is, nothing even to suggest they should have proceeded differently in this patient's care.

SUPERIOR COURT OF CONNECTICUT
April 8, 2005

The Superior Court of Connecticut dismissed the lawsuit.

There was no proof of substandard care for the AV fistula and no proof of how or why the fistula began to bleed.

The patient was disabled, in poor health and only marginally able to care for herself. It was not the fault of her caregivers that she was unable to appreciate or deal with the medical emergency which took her life at home. **Carchia v. Yale-New Haven Hosp., 2005 WL 1090685 (Conn. Super., April 8, 2005).**

Continuous Passive Motion: Court Finds Nursing Care Negligent.

Five days after bilateral knee replacement surgery a nurse became involved in the patient's care who was not familiar with the continuous passive motion (CPM) therapy which had been ordered by the physician.

One nurse put one CPM device on one knee and left the room. Another nurse, not familiar with CPM, put a second device on the other knee and left the room.

The confused patient ended up on his side with both devices going. As a result he developed a chronic foot drop which required orthopedic bracing.

The standard of care requires that two continuous passive motion devices cannot be used at the same time on both of the patient's legs.

A patient who has dementia or who is confused must be closely watched while continuous passive motion is in use.

MISSOURI COURT OF APPEALS
May 10, 2005

The Missouri Court of Appeals upheld a substantial jury verdict against the hospital for the nurses' negligence.

According to the nursing and medical experts whose testimony was accepted at trial, two CPM devices are never to be used at the same time. Further, a patient, especially an elderly, confused patient, requires frequent close monitoring while CPM is in use. Both of these errors and omissions were ruled the cause of the patient's injury. **Redel v. Capital Region Medical Center, __ S.W. 3d __, 2005 WL 1084105 (Mo. App., May 10, 2005).**

Long Term Care: Court Discusses Legal Issues Re Patient v. Patient Sexual Assault.

An eighty-three year-old female nursing home resident was assaulted by a sixty-one year-old resident of the same facility. Both residents suffered from dementia.

A lawsuit was filed against the facility on the victim's behalf. The facility asked the court for summary judgment, that is, they wanted the case dismissed outright rather than submitted for a jury trial.

The nursing home residents' bill of rights law gives every nursing home resident the legal right to safety, personal dignity and quality care.

However, for a facility to be liable for a sexual assault there must have been some reason for the staff to have foreseen it.

SUPERIOR COURT OF CONNECTICUT
March 24, 2005

The Superior Court of Connecticut ruled the evidence was not clear one way or the other and ordered a civil jury trial.

The court acknowledged that the nursing home residents' bill of rights gave this victim the right to a safe environment with her personal dignity protected.

However, for a patient to succeed in a patient v. patient sexual-assault lawsuit the staff must have negligently failed to take action in the face of some prior notice, such as improper advances or sexual acting-out, that should have alerted them to separate the two patients and watch, restrain or discharge the perpetrator. **Jane Doe v. Advisors Healthcare, Inc., 2005 WL 1089176 (Conn. Super., March 24, 2005).**