Patient's Unexplained Wrist Fracture: Court Looks At The Nursing Documentation To Blame Nursing Home, Exonerate Hospital.

The patient fell at home and broke his hip. He had hip surgery at a US Veterans Administration hospital and was discharged to a privately owned nursing home.

At some point he also fractured his wrist, most likely in a fall.

He sued the US government in Federal court claiming negligence by his VA hospital caregivers allowed the wrist fracture to occur, and he also filed a similar lawsuit in state court against the nursing home. The two lawsuits were consolidated in Federal District Court in the Northern District of Illinois.

The nursing home offered the patient a settlement, amount undisclosed, and the Federal judge dismissed the nursing home from the case in exchange for payment of the settlement.

The US attorney then argued for dismissal of the case against the US based on no negligence by the VA hospital's nursing caregivers. The court agreed and dismissed the US government from the case on the basis of no negligence.

Outcome of Court Case Turned On Nursing Documentation

The completeness of the nursing progress documentation and flow charting at the hospital, in contrast to the lack of proper documentation at the nursing home, was the deciding factor in the favorable legal outcome for the hospital.

Hospital Nursing Documentation

The patient's thorough initial nursing assessment on arrival included complaints of hip pain but no left-wrist symptoms. The nurse made note of his age, fall history, mobility problems, generalized weakness, medications and substance abuse, all of which pointed to a high-fall-risk classification for this patient.

The hospital nursing staff meticulously saw to it that a basic 24-hour nursing flow sheet was completed each day.

The early nursing flow sheets did, in fact, document reports of pain and signs of edema in his left wrist, for which he received medication. The early nursing progress notes documented that the edema subsided after two days.

A few days into his stay the patient began to experience dementia, most likely related to alcohol withdrawal and Wernicke-Korsakoff syndrome, and he had to be restrained to keep him in bed and to keep him from pulling out his IV lines.

While in restraints he was checked frequently by the nursing staff. Restraint monitoring included having a nurse at least once q shift place a finger under the wrist restraints to insure proper positioning, circulation and skin integrity. The daily protective-device flow sheets made no mention of any pain, swelling, deformity or instability in either wrist.

He had an IV in his left hand for his hip surgery. The surgical nurse's and anesthesiologist's notes mention no problem with the left wrist.

Nursing Home Nursing Documentation

The initial physical therapy assessment included an assessment of upper body strength capability for the purpose of going ahead with hip rehab. Nothing was found wrong with either wrist.

Then after admission there was an eleven-day period for which the nursing notes and new orders sheets were completely blank, the court said.

The silence was broken by a nursing note from a visiting nurse from the hospital stating he complained of left wrist pain, his left forearm was swollen and there was a deformity at the wrist. The nurse also noted his mental condition made him a poor historian and she was not able to determine from talking to him when or how it happened.

He was taken back to the hospital for x-rays and then had surgery to repair the wrist. Delay in detecting the fracture did compound the healing process and left him with a partial residual disability. **Anderson v. US, 2006 WL 862860 (N.D. Ill., March 30, 2006).**

The patient was discharged from the hospital to a nursing home to recuperate from hip surgery.

The patient sued both the hospital and the nursing home for a wrist fracture, claiming that all of his care givers, doctors, nurses, physical therapists, etc., missed the fact he somehow broke his wrist while under their care.

The hospital's nursing documentation and flow charting are very complete. There is no evidence of a wrist fracture.

The nursing home's nursing documentation, on the other hand, is completely blank for an eleven day period. All we have is a notation he suddenly could not move his wrist – a fact which was discovered by a visiting nurse from the hospital when she came to see him in the nursing home.

We also know that he was no longer in restraints at the nursing home, notwithstanding his mental status related to Wernicke-Korsakoff syndrome, and that he was repeatedly attempting to get out of bed.

UNITED STATES DISTRICT COURT
ILLINOIS
March 30, 2006