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Nursing Sample Case

Confused, demented, sedated, disoriented 80 year old patient was hospitalized for surgery for a broken (fractured) hip, and after surgery was not properly restrained, fell out of bed, and fractured her other hip.

According to the records, the patient was 80 years of age, tripped at home, and was admitted to the hospital with a fractured left hip. After stabilization, she was taken to surgery on May 8, by Dr. #1. She had a resection of the femoral head that was fractured and replacement with a prosthesis. This was with the "endoprosthetic bipolar replacement." According to the x-ray reports, the operation was properly done.

Following this operation, the patient had difficulty with her lungs and had to be intubated (an endotracheal tube placed in the windpipe). A Pulmonary consultant, Dr. #2, managed that aspect of her care properly.

On the evening of May 8, at 20:30, the nurses' notes show that the patient was resting quietly and "wrist restraints in place to bilateral wrists, circulation intact and unimpaired." A similar nurses' note was recorded at 21:00, at 21:15, and at 22:15, just before the patient was transferred to the surgical intensive care unit. I was unable to find any physician's order for soft wrist restraints during this part of her care.

Some hospitals have standing orders (automatic routine procedures) that nurses follow, or have automatic nursing standards that allow nurses to apply soft wrist restraints when indicated. In some hospitals, they can apply the soft wrist restraints, but it then requires the physician to be contacted for an order to be written.

In addition to the use of soft wrist restraints, which is quite restricting, patients can also be placed in a Posey jacket, which is like a straight jacket with the arms freed, and the jacket is tied to the bed from behind. This allows the patient limited mobility, depending upon how tight the Posey restraint is pulled down to the bed.

When patients are confused, the hospital is required to protect the patients from harm, which includes falling out of bed, or climbing out of bed and falling thereafter.

According to the records, the patient was doing well within the few days following the hip operation.

The first orders for wrist restraints that I can find in the records occurred at 2:59 a.m. on May 14. It says, "restraints -apply: soft ties to wrist - prn (as indicated). Follow restraint protocol". This was the telephone order of Dr. #3. Then, on May 14, at 9:14 a.m., there is a further order to restrain with the soft wrist restraints, which follows a hospital format, as noted on the restraints order dated May 14, at 08:45. It allows the nurses to use their judgement to release the restraints if the behavior checked off is absent. The behavior checked off here was to use the restraints during "episodes of confusion resulting in potential or actual injury to self. . ."

In the doctors' progress notes from May 13, it appears to state, "realizes her confusion today." On May 14, it notes, "very confused. Fell last night. X-rays ordered." That x-ray documented a fracture of the right hip, and she was properly taken to surgery by Dr. #1 on May 14, for an open reduction and internal fixation of the intertrochanteric fracture of the right hip. A hip screw and plate were used to reduce the fracture and maintain it in position. X-rays confirm that the operation was correctly done.

Usually, elderly patients are more confused at night, and one of the procedures utilized is to leave a night light on in the room. I cannot tell if this was done or not from the records.

Furthermore, the side rails need to be elevated and the bed placed at the lowest level so that if the patient should get out of bed or fall out of bed, their fall to the floor is reduced. It appears from the records that the side rails were elevated and the bed placed in the lowest position.

According to the nurses' notes, on May 11, the patient was noted to be confused and disoriented at times. This was 16:00. At 20:00 (8:00p.m.), it says, "confused -- most of the time."

On May 12, at 8:00 a.m., noon, and 4:00 p.m. (16:00), the three recordings under the "neurologic" section show that the patient was "confused, disoriented to place and time." Despite that, no Posey restraint or wrist restraints were requested by the nurses, or ordered by the physicians.

Under the "psychosocial" section of the patient care notes that are typed, at 16:00 on May 12, it says, "Affect: confused most of time." On that day, the patient only took 25% of her dinner, less than usual.

In the handwritten patient care notes, at 20:00 on May 12, it says, "confused to time and place." On May 13, at midnight, 4:00 a.m., 8:00 a.m., and noon and at 20:00, it says the patient was confused, she was disoriented. On May 13, the patient was incontinent of urine at times, which is the first note of such a problem in the records.

Under the "musculoskeletal" section, on May 13, at 20:00, it says, "patient confused and crosses legs." This is contraindicated following a hip operation. In the "psychosocial" section for that entire day, it notes the patient was confused.

Despite all the above, no restraints were requested or ordered.

On May 13, at 22:59, under the "safety" section, it says, "bed low/locked, bell in reach, side rails up, instructed to call for assistance." This is by a Nurse whose initials are #1. However, you cannot instruct a confused patient to call for assistance.

Under the handwritten patient care notes on May 13, at 09:00, the nurses state that the patient was "pleasantly confused." She received physical therapy. She was short of breath (SOB), and oxygen was applied. This was a new complaint. At 00:00, it says that she was confused. She had no complaints of pain at that time.

That patient care note, as all of them in the records, have a stamper plate in the upper right hand corner. However, the next page, which appears to be a continuation of the above notes, even though the bottom two lines on the previous page are blank, does not have a patient stamp on that right upper corner. This should be investigated.

Then, at 01:20, it notes that when the rounds were made, the patient was found nude sitting near the bathroom door. It notes the side rails were still up. With the assistance of two people, she was able to ambulate without complaints of pain at that time. They noted that the right and left lower extremities were intact neurovascularly. They noted there was no shortening or external rotation of the legs, which is usually seen with a hip fracture.

They notified the Physician at 01:45, and orders were written for soft restraints to be used as needed. At 02:00, it notes that the soft elastic restraints were applied.

At 02:45, they noted that the patient was out of the soft restraints and somehow was able to rise up or pull herself free from the restraints, and she was found pulling her torso over the side rail of the bed. The restraints were reapplied, and the patient was complaining of

pain in the right hip. Despite that, apparently no physician was notified until later that morning when the hip x-ray was obtained and showed a fracture of the right hip.

In my opinion, since this patient showed episodes of increasing confusion in the previous days, they should have notified the Physician who should have ordered a Posey restraint or soft wrist restraints. As an alternative, they could have arranged for a sitter, by the hospital or the family, to be at the patient's bedside continually to protect the patient from injury. None of this was done, and in my opinion, that is a departure from the accepted standards of care of Hospital #1, as well as the attending Physicians. All the physicians seeing this patient, including the orthopedic surgeon and the others, had a duty, in my opinion, to note her confusion and order appropriate restraints. Furthermore, the nurses had a duty to contact the treating physicians, who may not have read the Nurses' notes, and notify them that there was a problem and request that an order be written. Also, they could institute restraints on their own, and then request a physician's order to support that action of the nurse.

Based upon their documentation, it would appear the patient did not fracture her hip when she climbed out of bed at 01:20, but after the wrist restraints were not properly applied, the patient injured her hip during that subsequent episode that was documented at 02:45.

The patient was also sedated and receiving narcotic pain medication. That, plus her age of 80, plus her history of dementia, lung problems, previous fainting episode that required hospitalization during Easter, and her fall at home that precipitated the admission with the hip fracture, all should have required the patient to be properly restrained, particularly in the evening, when these patients are prone to become more disoriented. She had increasing urinary incontinence, was eating less, and was more confused. All this is well-documented in the records.

In my opinion, all the above would require appropriate bed restraints, which should have been at least the Posey jacket restraint. In my opinion, the proper use of that jacket restraint, or the proper use of soft wrist restraints, would have prevented the subsequent fracture from occurring.

Through discovery, obtain all of the standing orders of these physicians, as well as the hospital standing orders and nursing standards that the Hospital promulgated and were in effect during that time, with regard to the use of restraints.

The Defense would argue that the fracture was identified, she underwent successful surgery, and it only extended her hospital stay a small amount of time. Furthermore, this was paid for by Medicare insurance.

It would be important to document the current status of the mobility of the patient. She was going to be transferred to a skilled Nursing care facility, and was she ever able to be fully ambulated, having two hip fractures?

Because of her age, I would suggest you have a "day in the life" film taken to show the current status of the patient. I would also urge that a fast-track for trial be utilized because of her age and associated diseases.

In this case, I suggest that we first obtain the services of one of our Nursing Experts and then one of our Orthopedic Surgeons. You will have to conduct some discovery with regard to the standards I noted above, as well as deposing the Nurses that were in attendance during that night of May 13 and early morning hours of May 14.

We have these Experts available through our independent consulting staff.