

Focused Emergency Care Review

Fictional wrist injury case

Prepared by Stella Dolan, RN | SRD Legal Nurse Consulting

Illustrative sample only. All patients, clinicians, events, and record excerpts are fictional. This is not a review of an actual patient or an opinion on standard of care or medical causation.

Review purpose and principal findings

This sample examines how a right wrist injury was assessed, immobilized, and followed after an emergency department visit. The fictional excerpts document a fracture diagnosis, a post-splint neurovascular assessment, discharge instructions, and orthopedic follow-up. They leave questions about pain reassessment and a later referenced imaging report.

The next useful step is to obtain the underlying nursing documentation and the referenced follow-up radiology report. A missing entry in this limited excerpt set does not establish that an assessment or treatment did not occur.

Assignment and materials

Focus: Assessment, reassessment, splint documentation, discharge communication, and continuity of care from May 4 through May 14. No year is assigned to this fictional scenario.

Materials: Four constructed source excerpts, reproduced on page 3 as S1 through S4. Their original-style page labels match the reference scheme used for the companion chronology; those labels are fictional, not pages of an actual medical record.

Documented sequence of care

May 4, 09:10. Alex Morgan, MD, records right wrist pain after a fall, with distal circulation and sensation intact. [S1, fictional pp. 3-4]

May 4, 10:05. Jordan Ellis, MD, reports a nondisplaced distal radius fracture. [S2, fictional p. 8]

May 4, 11:00. The ED discharge entry records splint placement, intact post-splint neurovascular findings, and instructions for follow-up and return precautions. [S1, fictional pp. 5-7]

May 7 and May 14. Orthopedics documents continued pain, cast treatment, and a later reference to maintained alignment on repeat imaging. [S3-S4, fictional pp. 12-15]

Clinical observations and questions

Assessment before and after immobilization

Documented facts: The ED excerpts describe intact distal findings before and after splint placement. [S1]

Observation: These entries provide two assessment points. They do not describe every component of the examination or show whether interval assessments occurred.

Follow-up: Obtain the full nursing assessment and splint procedure documentation to establish the findings recorded, timing, and any changes between assessments.

Pain reassessment

Documented facts: Pain is reported on arrival and at orthopedic follow-up. The constructed excerpts contain no medication administration entry or post-intervention pain reassessment. [S1, S3]

Observation: These excerpts do not establish whether analgesia was administered, whether pain improved, or whether any intervention required further reassessment.

Follow-up: Review the medication administration record, orders, nursing flowsheets, and reassessment entries before drawing a conclusion about pain management.

Discharge communication and follow-up imaging

Documented facts: The ED entry includes return precautions and follow-up instructions. The May 14 orthopedic entry refers to maintained alignment on repeat imaging, but a separate May 14 radiology report is absent from this sample. [S1, S4]

Observation: The discharge entry records instructions, but does not establish the patient's understanding. The later note references an imaging finding that cannot be independently compared with a radiology report in this set.

Follow-up: Obtain the discharge instruction document and any acknowledgment or teaching entry. Request the May 14 imaging report and, if the assignment requires image interpretation, arrange review by an appropriate specialist.

Scope and limits

This review is limited to the fictional excerpts on page 3. It does not determine whether a breach occurred, whether care caused an injury, or whether a claim has legal merit. A complete assignment would define the clinical questions, obtain the relevant records, and identify any need for specialty expert review.

Discuss a record review: srdlegalnurse@gmail.com | 443.824.6531

Fictional source excerpts

These excerpts were created for this portfolio sample and are the sole source material for its observations. They are abbreviated teaching examples, not reproductions of actual records. Page labels are illustrative identifiers only.

S1 Emergency department documentation

May 4 | Alex Morgan, MD | Fictional pp. 3-7

09:10: Patient presents with right wrist pain after a fall. Distal circulation and sensation intact. [pp. 3-4]

11:00: Splint applied. Post-splint distal circulation and sensation intact. Discharge instructions include orthopedic follow-up and return for worsening pain, numbness, or changes in finger color or temperature. [pp. 5-7]

Excerpt limits: No medication administration record, interval nursing flowsheet, post-intervention pain score, or patient understanding entry is included.

S2 Initial radiology report

May 4, 10:05 | Jordan Ellis, MD | Fictional p. 8

Right wrist radiographs: Nondisplaced distal radius fracture.

S3 First orthopedic follow-up

May 7, 14:00 | Taylor Reed, MD | Fictional pp. 12-14

Patient reports continued right wrist pain. Cast treatment initiated. Follow-up planned.

S4 Subsequent orthopedic follow-up

May 14, 09:00 | Taylor Reed, MD | Fictional p. 15

Repeat right wrist imaging reviewed; alignment maintained. Continue cast treatment.

Record gap: A separate radiology report for the May 14 study is not included. The reference in the orthopedic note does not establish whether a separate report was created or supplied.

How to read this sample

Bracketed source IDs in the review point to the excerpts above. Documented facts describe what those excerpts state. Observations explain what can and cannot be established. Follow-up items identify the additional material needed to resolve the questions.

Companion chronology: srdolan.com/medical-chronologies-for-attorneys/