Session 3 Case Example:

On May 10, 2010 an 83 year old woman – alert and oriented times three - was admitted to the hospital with ESRD HD; s/p mechanical fall. (She fell on steps outside her home) CAD, CHF, EF 25%, ischemic cardiomyopathy, PUD, umbilical hernia, HTN, LLL pneumonia.

She resides in a single story home with her daughter and uses oxygen at 2 liters.

She was admitted to the medical surgical unit with the following MD orders:

- Full code
- Fluid restriction 1500cc/24 hours
- EcASA 81mg po qd
- Coumadin per HO at 8PM
- Lipitor 20mg po PM
- Metoprolol 12.5mg po bid
- Phoslo 667mg 3 caps po every meal
- Sensipar 30mg po at dinner
- Lactulose 30 cc every 12 hours
- Monitor oxygen saturations and give O2 2liter np to maintain oxygen saturation greater than 93%.
- Xray right ankle

During the beginning of her admission, she attempted to get out of bed on two occasions. Nursing staff prevented her from getting out of bed. The patient stated "I don't want to bother anyone dear – I know you are busy."

She received dialysis every other day and was working with physical therapy to assist with mobility and strength training. This patient required use of a walker and one person assist as she had "weakness in her lower extremities".

Nurses Notes (verbatim transcription):

5/14/10 vital signs 97; 102/49; 89; 20; PO2 93% on 2 liters np; no complaints this shift. (Nurse A)

5/14/10 7A-3P 97.8; 82; 20; 102/56; pulse ox 96% 2 liters. Patient requests dc home. Pt is not cleared by PT. MD updated. Edema cont bilat LE Denies sob or pain. Loose stool times 1. (Nurse B)

5/14/10 3P-11P 102/62; 96.5; 83; 20; 82-97%. OOB to chair. c/o disc APAP given with positive effect. No loose stools this shift. (Nurse C)

5/15/10 11P-7A 97.5; 100/58; 70; 20; pulse ox 94%. Pt was found on the floor at 5:15 by PCA. Redness noted on forehead and pt said she bumped her head on the floor. Small bump developed on the forehead. Denied any pain/discomfort. Moving all extremities without difficulty. Neuro

WNL. Ambien was given at approx. 1:30 for insomnia. Pt noncompliant with use of callbell for assist with transfers. Reminded pt to use callbell for assist with transfers. (Nurse D)

5/15/10 Supervisor note at 5:15: Called to room, found patient sitting on the floor; bleeding slightly from nares – swelling left forehead. She stated she forgot she could not walk alone and fell after taking a few steps from bed. All extremities show normal ROM with no co. No change in mentation – alert and oriented. Pupils equal. No injury except swelling on left forehead.

5/15/10 3P 97.8; 80; 103/69; 24; 96% on O2. Patient has large hematoma on left side of forehead. Patient family was called and updated. Patient refused 12PM meds due to dialysis appt at 1PM. Pt family updated that pt refused meds as pt explained kidney specialist was the one who advised her to not take meds right before dialysis. Ate well. (Nurse B)

5/15/10 3-11P 97.8; 84; 18; 94%; 96/52 Alert and confused at times. No complaints of pain or disc; no sob/resp distress noted. (Nurse C)

5/16/10 11-7A 97.8; 88; 20; 94%; 110/70 Pt appears to be sleeping. No co pain or disc; call bell is within reach. Added on – at am med pain pt denied pain. (Nurse D)

5/16/10 7A-3P 97.9; 86; 18; 116/52; Pox 94% RA; denies pain. Skin prep right heel; denies sob/cp.

5/16/10 3P-11P 116/70; 97.2; 85; 20; 97% on 2 l; oob to wheelchair; denies pain/disc; denies sob/resp distress. Neuros WNL secondary to fall. (Nurse C)

5/17/10 Pt found to have decreased responsiveness by PCA's at 5AM. BP hard to detect with a read of 87/53; noted to be diaphoretic. Pox 77% on 2 l; increased to 3.5L pulse ox increased to 90% Pt difficult to arouse and responded only to grunts. Neuros showed only sluggish pupil response and pt did not respond to prompts for hand grasps. Dr. M was contacted and pt sent for stat CT. (Nurse D)

5/17/10 Charge nurse: At 5AM pt was difficult to arouse; diaphoretic with bp 88/54. Pulse ox 80% in 2 liters; oxygen was increased to 3.5L. Pulse ox increased to 90%. Supervisor notified. Neuros checks – bilateral pupils sluggish. Dr. M was contacted and pt sent for stat head CT.

5/17/11 MD note: Patient was found on the floor in her room at 5:15am. She was alert and oriented times three and had a small bump on the left side of her forehead. Her neuros were normal and she was able to move all extremities without pain or difficulty. She was assisted back to bed and the nursing staff reminded her to call for assistance. She will have a CT scan of her head.

5/18/11 MD note: Patient was difficult to arouse, diaphoretic. Neuros were checked and her pupils were sluggish…… Patient transferred to ICU with a subdural hematoma, sepsis and end stage renal disease. ….At 1410, code called and patient unable to be resuscitated – time of death 1428.

Polish Your Expert Reports

Patricia Iyer MSN RN LNCC

- Every report needs a date.
- The report should be addressed to an individual at a law firm.
- The caption should be accurate. The caption is the name of the plaintiff versus the name the defendant such as Jane Morter vs. St. Theresa's Hospital.
- List all documents you reviewed, and give the name of the facility and the inclusive dates, such as Curley Nursing Home Admission 3/4/10-3/9/10. You do not have to list each part of the medical record you reviewed, such as nurses notes, order sheets, etc.
- Refer to the patient as Mr. or Ms. or Mrs. The only time it makes sense to use the first name of the patient is when the patient is a child.
- You may spell out dates in words, or in numbers. Both are correct. Consistency in noting dates is important. Pick one system and stay with it.
- Use complete sentences. Don't write like nurses chart.
- When referring to pain on a scale from 0-10, explain what this scale means. For example, "Pain is rated on a scale from 0-10 with 10 being the worst possible pain."
- Use clear sentences. Consider this sentence. "The nurses note stated upon entering room the resident was alert and oriented to person, place, time and talkative." As originally written, this sentence meant the resident was alert and oriented when she entered the room, not the nurse entering the room.
- Medical conditions which are spelled out are not capitalized.
- Do not use military time, such as 0100, which tends to confuse people. Use either a.m. or AM or p.m. or PM. There are no such abbreviation as am or pm.
- You are describing events that took place in the past so you should use past tense and not present tense in your report.
- Ages are hyphenated, such as 33-year-old or thirty-five year-old.
- Use headers to break up your report into sections, and do not include a blank line below the header. To do so makes it float between paragraphs instead of anchoring it to the text that follows.
- Make sure the spacing is consistent. You can adjust spacing of lines, such as selecting single spacing, in the home tab, paragraph, line spacing. Rarely should you use anything other than single spacing.
- Avoid passive voice. Passive voice is "He was taken to the emergency room" versus active voice: "He went to the emergency room." Activate your readability statistics on your word processor (check your help file on how to do this) and check the percentage of passive voice after it analyzes your document after the spell check. You should have less than 10% passive voice.
- Explain normal values the first time you cite a lab result. For example, "She had a glucose of 283 (normal is 70-100)."

- The first time you use a medical term, spell it out and then place the abbreviation after the term. After that, you may use the abbreviation. Example: The nurse inserted a nasogastric tube (NGT).
- Explain the standard of care. Do not assume the attorney can intuit it from your report. A defense expert explains the standard of care and then describes how the healthcare professional adhered to it. A plaintiff expert explains the standard of care and defines how the defendant deviated from it. You cannot skip the step of explaining the standard of care.
- Read your sentences out loud after you write them to be sure you were coherent.
- Carefully proofread your report before you send it to the attorney.

Session 3
Questions to be answered PRIOR to our Monday webinar

If your last name starts with the letter A through L, you are a plaintiff consultant. If your last name start with the letter M through Z, you are a defense consultant.

You have been given medical records related to a patient fall. Please answer the following questions:

Questions to answer if you are a plaintiff consultant:

1. Do you believe this is a valid case?
2. Describe your theories of liability.
3. Describe the strengths of the case.
4. Describe the weaknesses.
5. What type of expert is needed?
6. Describe the damages.
7. What additional information or questions would you ask?

Questions to answer if you are a defense consultant:

1. Is this a case you can defend?
2. Are there any individuals you would want to interview?
3. What angle of defense would you suggest?
4. Describe steps for your review.
5. What additional information or questions would you ask?

Fall Risk Assessment

New Admission

Date of admission:	
Over 3 months (0) points	
Less than 3 months (2 points)	2
History of falls:	
None (0 points)	
1-2 times (2 points)	2
Medicine Use:	
(1 point for each)	
Antihistamine	
Antiseizure	
Diuretics	
NSAIDS	
Antihypertensives	1
Benzodiazepines	
Hypoglycemic	
Psychotropics	
Narcotics	
Sedatives	
Memory/recall	full memory
Current season	
Location	
Staff names/faces	
Date	

Vision

Continence

Ambulation
Uses assistive device

16 or more points is risk of falling

NURSING ASSESSMENT: NURSES NOTE
TIME ASSESSED: Pt lying on stretcher in NAD. Able to speak without difficulty. +DOE with repositioning. Attempted to call dghtr but did not connect. Awaiting bed upstairs. States she is feeling hungry.

NURSING ASSESSMENT: NURSES NOTE
TIME ASSESSED: Transport called to help transfer pt to 4th floor with monitor and RN.

NURSING ASSESSMENT: SKIN
CONSTITUTIONAL: Complex assessment performed, Patient arrives ambulatory with steady gait to treatment area. History obtained from patient. Patient appears comfortable, Patient is cooperative, Patient is alert and oriented x 3, Patient appears in no acute distress, Patient's skin is warm and dry, Patient's mucous membranes are moist and pink.
SKIN: Patient denies pain to skin, Skin warm and dry, Skin color is normal, No rashes present, No Drainage, No skin ulcers noted, No obvious signs of skin trauma, Has rt lower leg sm cut with bandaid in place.
BRADEN SCALE: Mobility:, slightly limited (3), Moisture:, rarely moist (4), Sensory:, no impairment (4), Friction and shear:, potential problem (2), Nutrition:, adequate (3), Activity:, walks occasionally (3), Total score is 19.
TUBES AND PORTS: Dialysis port noted, to rt upper chest, Site inspection: CD and I.

NURSING PROCEDURE: BELONGINGS
TIME: Patient has the following belongings with him/her, Bra, Nightgown, Slippers, coat, Belongings are with the patient.
SAFETY: Side rails up, Cart in lowest position, Call light within reach.

NURSING PROCEDURE: IV
TIME: Patient's identity verified by, patient stating name, hospital ID bracelet, Indications for procedure: medication administration, IV established, 20 gauge catheter inserted, into left Forearm, #1 site, in 1 attempt, Saline lock established, Amount 10 cc.
SAFETY: Side rails up, Cart in lowest position, Call light within reach.

NURSING PROCEDURE: EKG CHART
TIME: Patient's identity verified by, patient stating name, patient stating birth date, Other indication SOB, 12 lead EKG Performed-left chest, After procedure, EKG for interpretation given to Dr. [redacted]
SAFETY: Side rails up, Cart in lowest position, Call light within reach.

NURSING PROCEDURE: CARDIAC MONITOR
TIME: Patient's identity verified by, patient stating name, patient stating birth date, Other indication for test SOB, Patient placed on cardiac monitor, Patient placed on non-invasive blood pressure monitor, Patient placed on continuous pulse Oximetry, O2 saturation reading 95%, Patient on cardiac monitor showing, sinus Tachycardia, Heart rate: 100, Disposable BP cuff applied, After procedure, patient tolerating monitoring, After procedure, alarms set and on.

SAFETY: Side rails up, Cart in lowest position, Call light within reach, Side rails padded.
VITAL SIGNS: BP: 93, / 66, Pulse: 92, Resp: 26, Pain: 0, O2 sat: 95, 2L.

NURSING PROCEDURE: ADMISSION
TIME: Bed assigned at 1220, Pt. admitted to room,

NURSING PROCEDURE: NURSE NOTES
TIME: Beverage given to patient, Lunch tray provided for patient, sitting up at side of cart eating without difficulty.

NURSING PROCEDURE: ADMISSION
TIME: Report called at 1235, Pt. admitted to room, Admission orders received and complete, Report called/faxed to RN, Patient transported via cart, Accompanied by transport, Accompanied by RN, Transported with monitor, Transported with oxygen, Transported with personal belongings, Admit Vital signs and pain score completed and documented below.
VITAL SIGNS: BP: 91, / 59, Pulse: 110, Resp: 22, Pain: 0, O2 sat: 95, 2L.

MEDICATION ADMINISTRATION SUMMARY
Drug Name: Levaquin, Dose: 500 mg , Route: IV, Status: Given, Time: 09:40 12/24/2009, Detailed record available in Medication Service section.

MEDICATION SERVICE
Levaquin: Order: Levaquin (Levofloxacin) - Dose: 500 mg : IV
Ordered by:
Entered by: Thu [redacted], [redacted] 09:18 ,
Acknowledged by: Thu [redacted], [redacted] 09:26
Documented as given by: Thu Dec 24, [redacted] 09:40
Patient, Medication, Dose, Route and Time verified prior to administration.
Verbal order read back and verified, Amount given: 500mg. IV site 1, Medication administered into right hand, Concentration confirmed prior to administration, Catheter placement confirmed via flush prior to administration, IV site without signs or symptoms of infiltration during medication administration, No swelling during administration, No drainage during administration, IV flushed after administration, Correct patient, time, route, dose and medication confirmed prior to administration, Patient advised of actions and side-effects prior to administration, Allergies confirmed and medications reviewed prior to administration, Patient in position of comfort, Side rails up, Cart in lowest position, Call light in reach.
: Follow Up : Medication infusion discontinued, at 1040.

PHYSICAL THERAPY EVALUATION AND RESIDENT PLAN OF CARE

Initial ✓ Interim_______ Discharge_______ Date:

Residents Name: Last_______ First_______ Sex: M_____ F ✓
Date of birth_____

Date of Admission:_______

MD order: Pt eval & treat

I.History:

Medical:(including any pertinent medications) S/p fall, ESRD, CAD, Post PCI, CHF, EF ?25%, Ischemic Cardiomyopathy, PVD, umbilical hernia, UTI, end stage renal disease

Social: lives c daughter. (I) c transfers + amb ØAD

Prior Level of Function: ↲

Principal Diagnosis: Medical Pneumonia 486
Therapeutic: Diff w walking ICD 9 Code_______ Date of Onset_______

LIMITATIONS

II.Cardiopulmonary: Pls see nursing notes

Activities: as tolerated c (A) 2it O_2

III.Mentation: Alert oriented X3

Previously @ U comm

IV. Physical: a. Range of motion: WNL ☐ WFL ☑ b. Strength: WNL ☐ WFL ☑

(B) LE	(B) LE

c.Tone: WNL ☐ WFL ☑ d. Reflexes: WNL ☐ WFL ☐

(B) LE	NT

V.Sensory/Motor:

Category	Impairment: Yes/No	Comments
Sensation	No	
Pain	yes	(B) LE
Swelling/Edema	Yes	"
Skin Integrity	yes	
Coordination	No	
Posture	Yes	
Balance	Yes	Sitting St/Dy ≥ F⁻ Stdg St/Dy F⁻

VI. Activities of Daily Living: Impairments noted: Yes ✓ No_____
Explain: Pls see OT eval

DISCHARGE SUMMARY

Patient Name:

MRN: 109428
Date of Birth: 11/16/1926

Date of Admission: 0

Date of Discharge:

DATE OF DEATH:

HPI:
Ms. [illegible]n 83-year-old Caucasian female who was discharged from [illegible] Hospital on Janu[illegible] 7th after an admission for pneumonia. She was readmitted the [illegible] with a fall and ankle injury. She was subsequently sent to a skilled nursing facility for rehab for her ankle and further treatment of pneumonia. She again fell at the skilled nursing facility 2 days prior to admission and over the last 2 days, had had decreasing levels of consciousness and mental status changes. She was found to be diaphoretic with mental status changes. A CAT scan in the [illegible] found the patient to have a right-sided subdural hematoma and a chest x-ray showed bilateral pleural effusions and vascular congestion. The patient was hypotensive with systolic blood pressures in the 70s. In the emergency department, she was given 250 mL of normal saline and started on a dopamine infusion at 10 mcg/kg per minute. She was transferred to the intensive care unit for hemodynamic and respiratory and neurologic management. On admission to the intensive care unit, [illegible] tachypneic and went to rapid atrial fibrillation with the heart rate of 170. She was treated with 2.5 mg of metoprolol x 2 doses. Her dopamine had been discontinued and was changed over to norepinephrine for blood pressure support. A right radial arterial line and a left femoral triple lumen catheter were placed emergently, and she required emergent hemodialysis to remove fluid for treatment of congestive heart failure and improvement in her breathing. ~~By completion of [illegible] 2hr hemodialysis treatment [illegible]~~

(MD omitted the next admission)

She was readmitted to the hospital and fell again.

3

THE JOHNS HOPKINS FALL RISK ASSESSMENT TOOL

FALL RISK FACTOR CATEGORY

Scoring not completed for the following reason(s) (check any that apply):

- ☐ Complete paralysis, or completely immobilized. Implement basic safety (low fall risk) interventions.
- ☐ Patient has a history of more than one fall within 6 months before admission. Implement high fall risk interventions throughout hospitalization.
- ☐ Patient has experienced a fall during this hospitalization. Implement high fall risk interventions throughout hospitalization.
- ☐ Patient is deemed high fall-risk per protocol (e.g. seizure precautions). Implement high fall-risk interventions per protocol.

COMPLETE THE FOLLOWING AND CALCULATE FALL RISK SCORE.	POINTS
AGE (**SINGLE**-SELECT) ☐ 60 – 69 years **(1 point)** ☐ 70 – 79 years **(2 points)** ☐ ≥ 80 years **(3 points)**	
FALL HISTORY (**SINGLE**-SELECT) ☐ One fall within 6 months before admission **(5 points)**	
ELIMINATION, BOWEL AND URINE (**SINGLE**-SELECT) ☐ Incontinence **(2 points)** ☐ Urgency or frequency **(2 points)** ☐ Urgency/frequency and incontinence **(4 points)**	
MEDICATIONS: INCLUDES PCA/OPIATES, ANTI-CONVULSANTS, ANTI-HYPERTENSIVES, DIURETICS, HYPNOTICS, LAXATIVES, SEDATIVES, AND PSYCHOTROPICS (**SINGLE**-SELECT) ☐ On 1 high fall risk drug **(3 point)** ☐ On 2 or more high fall risk drugs **(5 points)** ☐ Sedated procedure within past 24 hours **(7 points)**	
PATIENT CARE EQUIPMENT: ANY EQUIPMENT THAT TETHERS PATIENT, E.G., IV INFUSION, CHEST TUBE, INDWELLING CATHETERS, SCDS, ETC) (**SINGLE**-SELECT) ☐ One present **(1 point)** ☐ Two present **(2 points)** ☐ 3 or more present **(3 points)**	
MOBILITY (**MULTI**-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER) ☐ Requires assistance or supervision for mobility, transfer, or ambulation (2 points) ☐ Unsteady gait **(2 points)** ☐ Visual or auditory impairment affecting mobility **(2 points)**	
COGNITION (**MULTI**-SELECT, CHOOSE ALL THAT APPLY AND ADD POINTS TOGETHER) ☐ Altered awareness of immediate physical environment (1 point) ☐ Impulsive (2 points) ☐ Lack of understanding of one's physical and cognitive limitations (4 points)	
*MODERATE RISK = 6-13 TOTAL POINTS, HIGH RISK > 13 TOTAL POINTS TOTAL POINTS	

Figure 26.1 *Johns Hopkins Fall Risk Assessment Tool*

4.

The Johns Hopkins Hospital Nursing Practice and Organization Manual Volume II	Policy Number	328
	Effective Date	6/1/07
Subject FALL RISK ASSESMENT, PREVENTION AND MANAGEMENT, ADULT APPENDIX B: FALL PREVENTION INTERVENTIONS	Page	1 of 7
	Supersedes	11/1/06

Appendix B:
Fall Prevention Intervention Guidelines by Risk Category

LOW FALL RISK	MODERATE FALL RISK	HIGH FALL RISK
Fall risk score: 0-5 points	Fall risk score: 6-13 points Color code: YELLOW	Fall risk score: >13 points Color code: RED
Maintain safe unit environment, including: ▪ Remove excess equipment/ supplies/furniture from rooms and hallways. ▪ Coil and secure excess electrical and telephone wires. ▪ Clean all spills in patient room or in hallway immediately. Place signage to indicate wet floor danger. ▪ Restrict window openings The following are examples of basic safety interventions: • Orient patient to surroundings, including bathroom location, use of bed, and location of call light. • Keep bed in lowest position during use unless impractical (as in ICU nursing or specialty beds) • Keep top two side rails up (excludes box beds). In ICUs, keep all side rails up. • Secure locks on beds, stretchers, and wheelchairs. • Keep floors clutter/obstacle free (with attention to path between bed and bathroom/commode) ▪ Place call light and frequently needed objects within patient reach. Answer call light promptly. ▪ Encourage patients/families to call for assistance when needed. ▪ Display special instructions for vision and hearing. ▪ Assure adequate lighting, especially at night. • Use properly fitting nonskid footwear	• Institute flagging system: yellow card outside room and yellow sticker on medical record, Hill ROM flag (if available), assignment board/ electronic board. Implement measures listed under low fall risk and: • Monitor and assist patient in following daily schedules • Supervise and/or assist bedside sitting, personal hygiene, and toileting as appropriate. • Reorient confused patients as necessary • Establish elimination schedule, including use of bedside commode, if appropriate. Evaluate need for: • PT consult if patient has a history of fall and/or mobility impairment. • OT consult • Slip resistant chair mat (do not use in shower chair) • Activation of bed/chair alarm. • *Use of seat belt, when in wheelchair. * See Med/Surg Restraint Policy	• Institute flagging system: red card outside room and red sticker on medical record, assignment board/electronic board; Hill ROM flag, if available Implement measures listed under low/moderate risk and: • Remain with patient while toileting • Observe q 60 minutes unless patient is on activated bed or chair alarm. • If patient requires an air overlay, use side rail protectors. • When necessary, transport throughout hospital with assistance of staff or trained caregivers. Consider alternatives, e.g., bedside procedure. Notify receiving area of high fall risk. Evaluate need for the following : • Moving patient to room with best visual access to nursing station • Activated bed/chair alarm • Low bed • Protective devices, e.g. hipsters, helmets • 24 hour supervision/sitter • Physical restraint / enclosed bed (only with authorized prescriber order).

igure 26.2 Recommended Fall-prevention Strategies

5