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## Community – Home Care Case Study

### Introduction

This final case study is based on what you have learned in the course. Please reflect on the following prior to completing the case study:

1. What two general characteristics must your documentation include and why?
2. What are some risks or adverse events that may occur in a community/home care setting?
3. For each risk, what are the essential components of your documentation?

### Scenario

Please document the following scenario using the nursing process and your employer policy and procedures manual. Assume you have read the policies and procedures for documentation. Use the SBAR (situation, background, assessment, recommendations) communication tool in your notes.

- Use day/month/year and metric time.
- Use your name and designation.

### Client Specifics:

- Mrs. Clara Wolfe – 75 years old
- Dr. Sam Smith – primary physician
- Family contact / guardian – Anna Dubois, daughter and her 3 adolescent children share their home with Clara
- Medical diagnoses – hypertension, osteoporosis, osteoarthritis, mild cognitive impairment, Type 2 diabetes.
- Functional – ambulates with a walker.

## What happened?

The health care aide (HCA) Lana Biggs is scheduled to provide daily personal care assistance for Clara. The HCA calls you, the client home care coordinator, at 0800 and reports Clara fell with "minor injuries and a scrape on her left shin". The HCA reports to you that Clara fell during the night at approximately 0400, but seems to be fine this morning. The HCA states that Clara fell as she was getting up to use the commode and Clara denies loss of consciousness. Her daughter states that the fall was not witnessed, but she was awakened at night to assist her mother. Clara was placed back in bed by her daughter who says that her mom has been unsteady and slightly confused for the past two days. Clara has a 3 cm abrasion on her leg.

You instruct the HCA to monitor pain and mobility issues. You tell the HCA that you will be making a home visit this morning for an assessment of the client's condition and situation.

You visit the home that morning at 1100. You observe a 3 cm abrasion on the left shin. Clara is moving all limbs and has no complaints of pain at this time. BP 130/86, T 37.1 C (t), P94, R22. PEARL. You measure Clara's blood glucose level. You apply a clean dressing to the wound.

Clara tells you that she tried to get up at night and use the bedside commode when she got dizzy and fell.

Clara's physician was notified of her fall and your assessment data at 1230. New orders received for analgesic for pain and urine specimen. Dr. S. Smith is to be notified of urine results and client's pain.

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# Answer Key

## Community – Home Care Case Study

This final case study is based on what you have learned in the course. Please reflect on the following prior to completing this case study:

1. *What two general qualities must your documentation include?*
  - It must meet legal standards – your documentation must show that the standard of care was not breached. Your documentation proves that appropriate care or interventions were done and reflect this. Remember that care not documented means that the care was not done.
  - It must meet professional standards – your documentation would be compared to a colleague who would be practicing in similar circumstances. Your documentation must also show that you followed employer policies and procedures.
2. *What are some risks or adverse events that may occur in a community/home care setting?*
  - Falls
  - Medication mismanagement
  - Elder abuse
  - Isolation especially if living alone with little or no family support
  - Safety issues related to the environment (e.g. fire, wandering) or memory issues that could affect client judgment and reasoning
3. *For each risk, what are the essential components of your documentation?*
  - Falls – SBAR (situation, background, assessment, recommendations); safety measures
  - Medications – safety measures such as blister packs, family support/monitoring
  - Elder abuse – being alert for emotional and/or financial abuse (most common); watch for unexplained injuries
  - Isolation can lead to depression or even suicide (psycho-social needs)

- Any type of safety measures that have been put in place or safety concerns you have and what you did about these concerns

In this scenario you should consider risks to both you and the client and your plan of action:

- An adverse event – a client fall that was not witnessed
- Client data and report (SBAR – situation, background, assessment, recommendation) from an unregulated care provider such as an HCA. Ask the HCA to do her own documentation; did she fill out incident report and client notes in the client record using facts only?
- Use the nursing process as a guide for documentation. Be sure to include objective and subjective assessment data, your actions or interventions and the client response.

The following is a sample of what your documentation should resemble:

*19/ 06/2014 ----0800 ---- SBAR report received from L. Biggs, HCA. Client was found on floor at bedside by daughter, Anna Dubois, at 0400. Client stated to her daughter that she was "getting up to use the commode and became dizzy and fell." Daughter reports that client "did not hit her head, was able to move arms and legs, and had no complaints of pain when she was assisted back to bed". Home visit planned this am to assess situation. HCA to monitor client until home visit.*

*----- C. Williams, LPN*

*19/06/2014-----1100 ----Home visit. Client sitting in chair at kitchen table waiting for lunch. Client remembers having a fall during the night, as she was getting up to use the commode, but states "I'm fine". Daughter Anna states that client has no complaints of pain since her fall and is able to move freely and able to weight bear. Client denies pain at this time. Daughter reports that client's "memory is becoming worse." BP 130/86, T 37.1 C (t), P94, R22. Pupils equal and reacting to light. Blood glucose is 6.0. 3 cm abrasion on left shin cleansed with normal saline and dry gauze dressing applied. Daughter instructed to call home care office if any change in pain or mobility. Scatter rug removed at bedside, brakes on commode. Client instructed to rise slowly and states that she "will try to remember to do so". Daughter will purchase night light. -----C. Williams, LPN*

19/06/2014-----1230-----Dr. S. Smith notified by telephone of client's fall and condition. Assessment data relayed from above notes. New orders received for urine specimen and prn analgesic. Physician to be contacted if pain increases or mobility decreases. Will continue to monitor and call daughter this evening on client status. -----C. Williams, LPN