Continuing Care – Geriatrics 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 this case study:

1. What two general characteristics must your documentation include?

2. What are some of the risks or adverse events that may occur in a continuing care or a long term care setting?

3. For each risk, what are the essential components of your documentation?

Scenario

The following is a fictitious scenario in a long term care setting.

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

Client Specifics:

- Mrs. Anne Dixon – 87 years old
- Dr. Cyril MacLeod – primary physician
- Family contact – Matthew Dixon, son and named agent on personal directive
- Medical diagnoses – hypertension, osteoporosis, osteoarthritis, mild cognitive impairment, Type 2 diabetes
- Functional – ambulates with a walker, requires assistance with activities of daily living (ADLs); bathing, grooming, toileting.

What happened?

Care providers are alerted by hearing a loud crash and yelling in the client's room. Roommate, Emily Miles witnessed the fall.

At 1300 Anne is found lying on her right side on the floor at the bedside in front of the night table. She denies loss of consciousness, but is not sure if she bumped her head. She has a 2 cm abrasion on the right side of her forehead that is oozing blood. She is moving all her limbs and complains of pain at 6/10 for a "sore right shoulder". A large amount of bruising noted to the right shoulder. Vital signs are BP 130/86, T 37.1 C (t), P94, R 22. O2 sat is 95% on room air. PEARL.

Anne also tells care provider that she was trying to get the magazine from her night table so she could get up and read in her easy chair. When she got up, she became dizzy and fell. She is awake and aware of her surroundings after the fall. Her speech is clear and coherent and hand grips are strong bilaterally.

Physician notified of adverse event at 1315. Physician orders neurovital signs for 3 hours every 15 minute, 1 tablet of Tylenol # 3 for pain every 3 hours as required, x-ray of right shoulder.

Anne is assisted back to bed with a second care provider. The laceration on her forehead receives first aid treatment. Family is notified of the adverse event. Anne is instructed to ask for help when she gets up to read or to use the bathroom. She is to call the care provider if in pain. The client is left in bed in a safe position.

Answer Key

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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 must guide your documentation?*

   - Your documentation must meet both professional (competencies and standards) and legal requirements (how would your documentation succeed in the legal process).
   - Use your employer documentation system or use the nursing process as a guide to your documentation

2. *What are some of the risks or adverse events that may occur in a continuing care or a long term care setting?*

   - Falls
   - Refusal of treatment or procedure
   - Medication errors
   - Equipment failure
   - Family complaints or threats
   - Facility acquired infection
   - Injuries to/from other clients
   - Unexpected death

3. *In this scenario what is the adverse event and what are the essential components of your documentation?*

   The adverse event is a fall in a facility. The following are essential components when a fall occurs:

   - Client's condition when found
   - Direct quotes from client

- Physical assessment and injuries identified
- Safety initiatives to prevent further falls
- Physician notification, communication, examination, diagnostic studies
- Family notification
- Evidence of ongoing monitoring
- Other reporting requirements as facility policies and procedures (i.e. incident report, falls risk assessment)

In this adverse event, the physician was notified. The following checklist is implemented when notifying a physician or health care professional:

- correct date and time
- method of communication
- name of physician/health care provider
- why you telephoned – be specific
- new orders received or no new orders
- Use exact words of physician or health care professional.

You will be required to fill out an incident report form, monitor the client and implement your employer Falls Protocol.

The following is recommended documentation of the above scenario. How does this compare with your documentation?

02/06/ 2014----------1400---------- A loud crash and yelling heard in client's room. Roommate witnessed event. Client found lying on right side on the floor at the bedside in front of the night table at 1300. Client denies loss of consciousness or bumping her head. 2 cm abrasion oozing bright red blood noted on right side of forehead. Moving all limbs, but complains of a "sore right shoulder". Circular bruising of 10 cm noted to the right shoulder. Pain in right shoulder is 6/10 as per employer pain scale. Vital signs: BP 130/86, T?, P94, R22. O2 sat is 95% on room air. Pupils equal and reacting to light. Client states that she was trying to "get the magazine from her night table so she could get up and read in her easy chair". When she got up, she became dizzy and fell. Awake and aware of surroundings when asked. Speech is clear and coherent and bilateral

hand grips strong. Dr. C. MacLeod notified of injuries and fall at 1315. New orders received. Physician requests a call at 2000 for updated report on client's condition. Client assisted back to bed with a second care provider. 3 cm laceration on forehead cleansed with normal saline and 2X2 dry dressing applied. Ice pack to right shoulder. Son, Matthew Dixon notified and will come to visit this evening. Client instructed to ask for help when getting out of bed. Client agrees. Resting in bed – magazines and call light within easy reach and bed in lowest position. Refuses side rails. Client to call if pain increases. Employer Falls protocol implemented. Will continue to monitor.----------C. Williams, LPN

Assignment Reflection – Take away thoughts:

- You could state that "oriented to time, person and place when asked", instead of stating "awake and aware of surroundings". Or you could state the responses to your questions that assess orientation.
- You could expand on the witnessing roommate's comments if there were any, without identifying her.
- It is not advisable to document the physician orders in the progress notes, but it is appropriate to state if "new orders" or "no new orders". Remember to state the exact words of the physician to you or if you reported this incident to a supervisor.
- Remember to include safety measures and instructions or teaching that you did; also, the results of your discussions.
- Have you asked a colleague to analyze your documentation to see if he or she can detect any gaps or unclear statements?
- Have you adequately documented on the emotional status and pain of the client?
- And the final question. Does your assignment meet both legal and professional requirements?