



Medical Opinion - XXXX

Brief summary:

Mr. XXXX was an 84-year-old male who was taking the following drugs that act on the brain: Xanax, Risperidol and Quetiapine.

He was admitted to XXXX Nursing Home on 03/25/YYYY. At that time, he required wheelchair and 2 person assistance to transfer him from/to wheelchair.

On 04/14/YYYY, it was noted that Mr. XXXX was awake and restless and trying to crawl over the rail on his bed. On 04/14/YYYY at 06:00, the patient was found lying on his belly in a grass past the annex door outside the home. A 'redness' was noted at the right temple and right cheek.

On the same day (04/14/YYYY) at 09:15, the patient was found on the floor near the nurse station. He was noted to have laceration just above and below the right eye. He was transferred to ER at XXXX.

At XXXX, he was investigated with CT scan that showed a 2cm left thalamic intra-parenchymal hemorrhage extending superiorly. There was intraventricular extension bilaterally, more prominent on the left. No epidural or subdural hematoma. The ventricles, basal cisterns, and sulci were prominent consistent with age related volume loss.

On the following days, his condition did not improve and he expired on 04/21/YYYY.

Opinion:

On reviewing the records, it is found that Mr. XXXX had got **the following risk factors for 'fall'**:

1. His confused state of mind. (Ref-1)
2. His medications i.e., Risperidol, Xanax, and Quetiapine. (Ref-1)

With these factors he had to be handled carefully in the nursing home.

The following are the **lacunae found in the care of Mr. XXXX**, who had the above said risk factors for fall, major risk factors for morbidity and mortality of senior citizens, in the nursing home.

1. There was no fall assessment risk score that would help the caretakers at the nursing home for planning to prevent fall.
2. There was no proper plan to take care of Mr. XXXX in the nursing home. (Ref-2)

These are the two basic major steps in preventing a fall and thus mortality and morbidity.

There is no record that state that a Physician had visited the patient and that a fall risk assessment was done for this patient. Also, there was no record that mentions that there was a proper plan how to take care for Mr. XXXX.



After he fell down at 06:00, he fell down again at 09:15. It is not known why this happened and **how they did allow this to happen** as they should have done something to prevent 'repeat' fall. We note that, after a fall, the patient has to be assessed for the fall (Ref-3) and a plan has to be drawn to prevent in the future. But **they did not take enough care to prevent the second fall.**

References:

Ref-1:

<http://www.premierinc.com/safety/topics/falls/>

Fall prevention

Cause of falls

Intrinsic risk factors (**i.e., integral to the patient's system, many of which are associated with age-related changes**):

- Previous fall - studies have cited a history of falls as a significant factor associated with patients being more likely to fall again.
- Reduced vision – vision affected by, for example, a decline in visual acuity, decreased night vision, altered depth perception, decline in peripheral vision, or glare intolerance.
- **Unsteady gait - manner and style of walking.**
- Musculoskeletal system – impact from factors such as muscle atrophy, calcification of tendons and ligaments, and increased curvature of the spine (osteoporosis) are associated with ability to maintain balance and proper posture.
- **Mental status – status affected by confusion**, disorientation, inability to understand, and impaired memory.
- Acute illnesses – rapid onset of symptoms associated with seizures, stroke, orthostatic hypotension, and febrile conditions.
- Chronic illnesses - conditions such as arthritis, cataracts, glaucoma, dementia, diabetes and Parkinsonism.

Ref-2:

<http://www.hg.org/article.asp?id=18861>

There are five key areas of inquiry in determining the legal liability of nursing homes for falls:

1. **The assessment of the resident – if the assessment under states the true risk of the resident falling, then the likelihood is that there will not be a proper care plan put into place.**
2. **The adequacy of the care plan – are interventions being put into place to prevent falls, and if so, are these adequate in light of the risk of falling.**
3. The implementation of the care plan – the best care plan in the world will not prevent falls unless the plan is actually being carried out on a day-to-day basis.
4. The review of the care plan – once the care plan is out into place, is it in practice alleviating the risk of falls.



5. The revision of the care plan – if the care plan that is currently in place is not effective at preventing falls, then it needs to be changed to include more effective and aggressive measures.

Ref-3:

<http://www.premierinc.com/safety/topics/falls/>

Interventions and prevention strategies

When to conduct a risk assessment

The assessment for risk factors, which is usually performed by nurses, commonly utilizes a system that assigns points to specific risk factors. The level of risk and subsequent fall precaution measures such as “standard” or “high risk” precautions are then initiated based on the range in which the patient scores (e.g., low, medium or high risk).

Suggested timing for risk assessments include:

1. **On admission - risk assessment data should be entered into the admission database as soon as possible after admission.**
2. **Changes in a patient’s status - (physiological, functional or cognitive change).**
3. **Whenever a fall occurs - data should be entered anytime a patient or resident experiences a fall.**
4. Periodically during a hospital stay, or when transported, including transfers to another patient care unit
5. Quarterly, at minimum, or other defined time periods in long-term, chronic and residential care settings.