FALL Case Study #1

During a SOC visit, the patient is assessed as a 69 y/o male, recently being discharged from the hospital with an admitting diagnosis of new onset of CHF. He has a history of hypertension, type II diabetes and a new stage II wound on the plantar side of his right foot. He reports the hospital gave him a cane to use for ambulation but states he doesn’t need it since he can ambulate “better without it”.

During the SOC, the safety assessment finds the house has 5 concrete steps with a fixed hand rail to enter the home, multiple throw rugs with stick-on backing on a hardwood floors. The patient’s kitchen and bathroom are on the main floor while his bedroom is up 10 steps with handrail. He lives alone with his daughter living down the street and will be checking on him a few times a week. When asked about falling, he reports he has fallen in the past year “a few times, but that’s only because I slipped”. He reports good vision and hearing and has demonstrated these during the assessment.

The physician discharge orders include:
1. Home health evaluation
2. Up ad lib, when sitting, keep right foot elevated
3. PT evaluation for strengthening
4. Low sodium diet
5. May shower – keep right foot dry
6. vacuum dressing to right foot to be changed 3 / week (wet-to-dry dressings TID until equipment available)
7. digoxin 0.25 mg po qd
8. furosemide 20 mg po qd
9. furosemide 10 mg po x1 PRN weight gain ≥ 2 lbs / 24 hrs or ≥ 5 lbs / week
10. calcium supplement 600 mg po qd
11. eszopiclone 2 mg q hs
12. multivitamin 1 po qd
13. lisinopril 20 mg po qd
14. clonazepam 0.5 mg po bid prn anxiety
15. Insulin 70/30 26 units sq every morning
16. blood glucose monitoring ac and hs – call if blood sugars <80 or >250

Questions:
1. What is your priority concern for this patient?
2. What level of fall risk would this patient be classified using agency fall risk assessment tool?
3. What fall precautions would you plan to implement?
4. As the person completing the SOC, would you contact the physician about any of your findings? If so, which ones?
5. Do you see a need to involve the patient’s daughter during this SOC or subsequent visit(s)? Why or Why not?
FALL Case Study #2

You prepare to visit an established 47-year-old female patient with end-stage COPD with orders for a palliative care evaluation. Upon knocking on the door for the scheduled visit, you hear the patient yelling “come in and help me”. You enter the home and find the patient lying in the kitchen floor on her back next to a stool which has been toppled over. She has a visible ecchymotic area on her right face / cheek with a small amount of dried blood on her hand. She tells you she was trying to reach something in the cabinet over the stove yesterday and fell and hasn’t been able to move since then.

1. List your actions in order of priority – include notifications and your HHA policies.
2. What documents need to be completed and when?
3. What alterations, if any, need to be made to the patient’s care plan?
4. Would this patient need to have her medications re-evaluated?