RECOMMEND REJECTION

Contact Information

Firm		**Phone Number**	
Caller Name		**Alt Phone 1**	
		Alt Phone 2	
Language	English	**Email**	
Timezone	Eastern		
Number of Attempts		**Address**	

Case Type Information

Case Type	Medical Malpractice
Information	"Charting in the Evaluation Synopsis Box Outline should be as follows: 1)RESULTING DAMAGE: List damage or none. 2)ALLEGED NEGLIGENCE: chief complaint and quick summary of incident. 3)FURTHER TREATMENT: state details of further treatment, unknown or none. 4)RELEVANT PAST MEDICAL HISTORY: list health conditions and any dx relevant to medical malpractice claim. 5)REVIEWERS NOTE: The nurses impression here. Cite if the condition or complication is common with said procedure and/or Cite any known characteristics associated with procedures or condition. *Above is the order that the information should be covered. Please use the headers provided. "

Injured Info

Verbal consent obtained	☑
Relation to Injured	Self
Name of Injured	
Injured Date of Birth	
Height	5'4"
Weight	150
Date of Injury	8/9/2016
US State where injury occurred	South Carolina
Nature of Injury	Injured

Married	
Dependents	

Evaluation Synopsis

Resulting Damage	Foot injury
Alleged Negligence	During an intake interview and examination for a clinical trial conducted by Clinical Trials of South Carolina (CTSC) for the migraine medication lasmiditan PNC reports the examiner dropped a clipboard onto PNC's foot striking the foot edge first on the cuticle area of a toe causing bleeding. PNC reports having the facility document the occurrence in an incident report. PNC advises she has a copy of the incident report signed by the operations manager of the facility. PNC further advises she was seen at her primary care office and "the PA that I saw ordered an Xray to make sure nothing was wrong". The Xray reportedly demonstrated "no definite evidence of acute fracture or dislocation". Per PNC she has been offered a $50 "inconvenience fee" to cover the cost of medical examination and has been advised by CTSC personnel that “our office doesn't pay medical bills”.
Further Treatment	Unknown
Relevant Medical History	None
Add Reviewer's Note	This matter sounds in the realm of personal injury and demonstrates of damages that were identified on Xray. There is no evidence of a deviation from the standard of care in this matter.

System Information

Intake	104531	**Last Modified By**	Martin Ginsburg, 8/13/2016 11:48 AM

RECOMMEND REJECTION

Contact Information

Firm		**Phone Number**	
Caller Name		**Alt Phone 1**	
		Alt Phone 2	
Language	English	**Email**	
Timezone	Eastern		
Number of Attempts		**Address**	

Case Type Information

Case Type	Medical Malpractice
Information	"Charting in the Evaluation Synopsis Box Outline should be as follows: 1)RESULTING DAMAGE: List damage or none. 2)ALLEGED NEGLIGENCE: chief complaint and quick summary of incident. 3)FURTHER TREATMENT: state details of further treatment, unknown or none. 4)RELEVANT PAST MEDICAL HISTORY: list health conditions and any dx relevant to medical malpractice claim. 5)REVIEWERS NOTE: The nurses impression here. Cite if the condition or complication is common with said procedure and/or Cite any known characteristics associated with procedures or condition. *Above is the order that the information should be covered. Please use the headers provided. "

Injured Info

Verbal consent obtained	☑
Relation to Injured	Self
Name of Injured	
Injured Date of Birth	
Height	5'11"
Weight	318
Date of Injury	
US State where injury occurred	South Carolina
Nature of Injury	Injured
Married	

Dependents

Evaluation Synopsis

Resulting Damage

Infection and delayed healing

Alleged Negligence

PNC underwent bilateral knee replacement X/XX/2016. On X/XX/2016 he was re-admitted for cellulitis/edema – infection – and reports being unable to do therapy. PNC advises they “kept increasing my pain medication” and that “my legs had a fever”. A mid-line (tunneled peripherally inserted intravenous cather) for IV antibiotic (Abx) administration was placed and they “kept me in there about another 10 days”. On about ~X/XX/2016 “they sent me home” still on IV Abx and “a home health nurse (HHN) came out and helped me also” for ~10 days. Due to complications with midline “positional” (the line would suffer restriction or occlusion related to the position of the patient's arm) PNC went back to hospital for PICC (peripherally inserted central catheter) because they “couldn't get the IV to work”. PNC states “McCloud in Dillon said there was nothing they could do they'd have to send me to McCloud in Florence” “I went into the ED and they put a PICC line in so I could get the last week or so of Abx”. PNC reports R leg still weak (quads weak) - though “getting better” - not getting full extension of R knee at this point.

“I went back to the doctor and he said it looked like the cellulitis is gone and I still have phlebitis” ID appt 8/2/2016 – “didn't follow-up with it” – “my leg wasn't tight anymore the skin wasn't tight anymore” “I was taking the aspirin [81mg]”

PT ongoing – appt c doctor X/XX/2016 to re-eval for return to work

Further Treatment

Unknown

Relevant Medical History

R hip replacement (2010) with re-do (2012)
Denies diabetes

Add Reviewer's Note

Infection is a known complication of any invasive procedure and is not presumptive for a deviation from the standard of care.

The interventions upon report of infection have led to PNC reporting a resolving infection with ongoing post-operative physical therapy for a bilateral knee replacement. While replacing both knees in a single operative episode is uncommon it could be argued that in a patient with a body mass index of 44 (normal range 18.5 - 25) and with Class III obesity, opting for a single post-operative period can enhance patient outcome.

There was certainly a delay in healing related to the infectious process but in the absence of a breach in the standard leading to the infection, there is no attributable damage to the PNC.

System Information

Intake 104486

Last Modified By Martin Ginsburg, 8/13/2016 12:03 PM

RECOMMEND REJECTION

Contact Information

Firm		**Phone Number**	
Caller Name		**Alt Phone 1**	
		Alt Phone 2	
Language	English	**Email**	
Timezone	Eastern		
Number of Attempts		**Address**	

Case Type Information

Case Type	Medical Malpractice
Information	"Charting in the Evaluation Synopsis Box Outline should be as follows: 1)RESULTING DAMAGE: List damage or none. 2)ALLEGED NEGLIGENCE: chief complaint and quick summary of incident. 3)FURTHER TREATMENT: state details of further treatment, unknown or none. 4)RELEVANT PAST MEDICAL HISTORY: list health conditions and any dx relevant to medical malpractice claim. 5)REVIEWERS NOTE: The nurses impression here. Cite if the condition or complication is common with said procedure and/or Cite any known characteristics associated with procedures or condition. *Above is the order that the information should be covered. Please use the headers provided. "

Injured Info

Verbal consent obtained	☑
Relation to Injured	Self
Name of Injured	
Injured Date of Birth	
Height	5'11"
Weight	318
Date of Injury	
US State where injury occurred	South Carolina
Nature of Injury	Injured
Married	

Dependents

Evaluation Synopsis

Resulting Damage

Infection and delayed healing

Alleged Negligence

PNC underwent bilateral knee replacement X/XX/2016. On X/XX/2016 he was re-admitted for cellulitis/edema – infection – and reports being unable to do therapy. PNC advises they “kept increasing my pain medication” and that “my legs had a fever”. A mid-line (tunneled peripherally inserted intravenous cather) for IV antibiotic (Abx) administration was placed and they “kept me in there about another 10 days”. On about ~X/XX/2016 “they sent me home” still on IV Abx and “a home health nurse (HHN) came out and helped me also” for ~10 days. Due to complications with midline “positional” (the line would suffer restriction or occlusion related to the position of the patient's arm) PNC went back to hospital for PICC (peripherally inserted central catheter) because they “couldn't get the IV to work”. PNC states “McCloud in Dillon said there was nothing they could do they'd have to send me to McCloud in Florence” “I went into the ED and they put a PICC line in so I could get the last week or so of Abx”. PNC reports R leg still weak (quads weak) - though “getting better” - not getting full extension of R knee at this point.

“I went back to the doctor and he said it looked like the cellulitis is gone and I still have phlebitis” ID appt 8/2/2016 – “didn't follow-up with it” – “my leg wasn't tight anymore the skin wasn't tight anymore” “I was taking the aspirin [81mg]”

PT ongoing – appt c doctor X/XX/2016 to re-eval for return to work

Further Treatment

Unknown

Relevant Medical History

R hip replacement (2010) with re-do (2012)
Denies diabetes

Add Reviewer's Note

Infection is a known complication of any invasive procedure and is not presumptive for a deviation from the standard of care.

The interventions upon report of infection have led to PNC reporting a resolving infection with ongoing post-operative physical therapy for a bilateral knee replacement. While replacing both knees in a single operative episode is uncommon it could be argued that in a patient with a body mass index of 44 (normal range 18.5 - 25) and with Class III obesity, opting for a single post-operative period can enhance patient outcome.

There was certainly a delay in healing related to the infectious process but in the absence of a breach in the standard leading to the infection, there is no attributable damage to the PNC.

System Information

Intake 104486

Last Modified By Martin Ginsburg, 8/13/2016 12:03 PM

RECOMMEND REJECTION

Possible Product Liability claim

Contact Information

Firm		**Phone Number**	
Caller Name		**Alt Phone 1**	
		Alt Phone 2	
Language	English	**Email**	
Timezone	Eastern		
Number of Attempts		**Address**	

Case Type Information

Case Type	Medical Malpractice
Information	"Charting in the Evaluation Synopsis Box Outline should be as follows: 1)RESULTING DAMAGE: List damage or none. 2)ALLEGED NEGLIGENCE: chief complaint and quick summary of incident. 3)FURTHER TREATMENT: state details of further treatment, unknown or none. 4)RELEVANT PAST MEDICAL HISTORY: list health conditions and any dx relevant to medical malpractice claim. 5)REVIEWERS NOTE: The nurses impression here. Cite if the condition or complication is common with said procedure and/or Cite any known characteristics associated with procedures or condition. *Above is the order that the information should be covered. Please use the headers provided. "

Injured Info

Verbal consent obtained	✓
Relation to Injured	Self
Name of Injured	
Injured Date of Birth	
Height	5'5"
Weight	170
Date of Injury	
US State where injury occurred	South Carolina
Nature of Injury	Injured

Married	
Dependents	

Evaluation Synopsis

Resulting Damage	Pain, impaired activities of daily living (ADLs)
Alleged Negligence	In late 2014 PNC began experiencing chronic low back pain and sought treatment through her Primary Care Physician (PCP). PCP referred PNC to Dr Bauble (Bauble) a spine and ortho specialist. Following MRI of the spine, escalating therapies, as recommended, began with physical therapy (failed) and was followed by epidural injections to reduce inflammation and pain (failed) and after attempting to address the issue with conservative management, it was recommended PNC undergo disc replacement at the space between the 4th and 5th lumbar vertebrae (L4, L5). In early January 2016 PNC underwent robotic surgical disc replacement of the L4-L5 disc. PNC during a follow-up visit reported to Bauble “I was asking him about my left leg – it was numb – all the way from the foot to the knee – the pain goes around front to my L hip – ain on the whole leg – shooting, burning pain in the bottom of my where where it's numb – I walk with a foot drop” “if I'm sitting down I can't lift my leg off the floor” “it feels like I have a charlie horse all the time”. Imaging studies revealed a collapse of the implanted disc and surgery for replacement of the collapsed prosthesis was recommended. A second surgery was performed in March of 2016 “to correct what had collapsed” with PNC reporting being told of “bone fragments was in my back” and that “it had collapsed on the nerve”.
Further Treatment	Unknown
Relevant Medical History	Denies prior history of spinal/orthopeadic/bone injury or disease
Add Reviewer's Note	* * * * * N.B. * * * * * As noted, this matter appears to sound in the realm of product liability, rather than professional negligence. As regards professional negligence, there is insufficient information indicating such has occurred and, therefore, there is no identifiable deviation leading to injury. This case may sound in product liability, though it is impossible to ascertain whether this is a known product failure as PNC is unable to provide details of the prosthesis used. A failure of such a product could certainly have led to the symptoms this PNC has, and will likely continue to experience. For reasons of potential product liability claim, record review is indicated for a firm handling such claims to determine whether there is sufficient history to support a cause of action. As professional negligence, however, there is no suspicion of failures that would support a case.

System Information

Intake	104243	**Last Modified By**	Martin Ginsburg, 7/13/2016 10:43 AM

RECOMMEND ACCEPTANCE

Contact Information

Firm		**Phone Number**	
Caller Name		**Alt Phone 1**	Cellphone:
		Alt Phone 2	Cellphone:
Language	English	**Email**	
Timezone	No Timezone Associated		
Number of Attempts		**Address**	

Case Type Information

Case Type	Medical Malpractice
Information	"Charting in the Evaluation Synopsis Box Outline should be as follows: 1)RESULTING DAMAGE: List damage or none. 2)ALLEGED NEGLIGENCE: chief complaint and quick summary of incident. 3)FURTHER TREATMENT: state details of further treatment, unknown or none. 4)RELEVANT PAST MEDICAL HISTORY: list health conditions and any dx relevant to medical malpractice claim. 5)REVIEWERS NOTE: The nurses impression here. Cite if the condition or complication is common with said procedure and/or Cite any known characteristics associated with procedures or condition. *Above is the order that the information should be covered. Please use the headers provided. "

Injured Info

Verbal consent obtained	☑
Relation to Injured	Spouse
Name of Injured	
Injured Date of Birth	
Height	6'2"
Weight	195
Date of Injury	
US State where injury occurred	South Carolina
Nature of Injury	Injured

Married

Dependents

Evaluation Synopsis

Resulting Damage

Untreated metastatic cancer

Alleged Negligence

During a routine visit to his primary care physician Dr Bauble (Bauble) in September of 2015, Mr. Robbins (Pt) was advised of a mass in his R lung noted on chest x-ray)CXR). Pt was referred to Dr Curry (Curry). a thoracic surgeon for evaluation for surgery. a PET scan with radionucleotides used to examine for metastatic disease was performed and Klien is reported by Caller to have said "I'm sorry to have to tell you this but you don't just have lung caner, you also have colon cancer" indicatinig an area of the PET images also stated "this section of your colon is lighting up positive for cancer" and she further said "I want you to have another colonoscopy". Upon being told Pt had had a recent colonoscopy and was told it was a normal study, Bauble repeated her recommendation and Pt underwent a second colonoscopy with Dr Snyder (Snyder), the gastroenterologist, reporting to Pt and Caller “he has a narrowing of the colon, but I don't think it's cancer” “diverticulosis”.

Pt underwent R pneumonectomy (removal of entire R lung) the following day by Curry and was followed post operatively by Dr Jeffers (Jeffers) for oncology. Approximately 2-3 weeks after surgery Pt began his chemotherapy (chemo) regimen (medications unknown) which was scheduled once every three weeks for four treatments. This series ended in January 2016.

Approximately 6 weeks post chemo in late February Pt advised Snyder “I have a blockage – can't drink anything – I'm vomiting everytime I eat or drink”. Snyder performed an esophagogastroduodenoscopy (EGD) and diagnosed Pt with ulcers which were treated medically and a follow-up visit scheduled. ~6 weeks later and advised ulcers cleared “everything looks good”.

Pt advised Caller and Snyder “but I still can't eat – every time I try to eat I either vomit or have diarrhea” “he couldn't even hardly urinate at this point” “I took him to Trident and told them he was sick” Xray - “they told him there's no blockage” “bloody stools”. Snyder responded “he said it's your gallbladder” and referrred to radiology for “a test to check his gallbladder” - the study came back as within the normal range and Pt was referred to general surgeon Dr Simpson (Simpson) for cholecystectomy (chole) (gall bladder removal). Advising that the gallbladder emptying studies are not always accurate, Simpson is reported to have told Pt “even though it's within the normal range let's take it out anyway”.

On the morning after chole Pt advised Caller “he said it's not my gallbladder” “it's the same pain” and on 6/9/2016 Caller transported Pt to Johnston ED and insisted the ED physician perform a digital rectal exam as that was where PT was reporting a feeling of pressure.Upon examination the ED physician advised Caller “he has colon cancer – there's blood and pus coming out of him”.

Pt was admitted “they started him on Abx – Dr Simpson was called – he called another GI doc to try to place a stent” in the colon to dilate the colon. Caller reports that “after about a week they put a feeding tube on him and it blew him up – he looked none months pregnant” “when Simpson came in (6/23/2016) Thursday he said this isn't working I'm not going to wait until Monday I'm going to have to do surgery Friday” “I don't think it's cancer – we'll have to wait for the pathology report” “I still treated it like it was a cancer because I wanted to make sure – took lymph nodes – the margins are clear”.

The pathology report has confirmed metastatic lung cancer that has transferred to the colon. Caller reports being told Pt disease is not curable though palliation is being offered.

Further Treatment

Unknown

Relevant Medical History

denies relevant history

Add Reviewer's Note

The complexity of this issue calls for review based upon the qualifying questions and is presented below.

1) Is there an apparent or suggested deviation in the standard of care?
There is, from the information available, a failure to diagnose colon cancer and a failure to recognize cancer demonstrated on PET scan and treat accordingly.

2) Is there a significant or permanent injury or damage attributable to the deviation?
There are assumptions that must be made to adequately address this question. This Pt is now reported to have terminal illness. The metastatic disease was already present when referred to Snyder. The failure to diagnose/treat the distant disease likely lead to its becoming an unsurvivable disease. If this likelihood is supported by medical review, the significant injury is death of the Pt.

3) Is there a direct link between the deviation and the injury or damage?
A link can only be established insofar as the continued growth of the metastatic cancer lead to its not being removed during the same surgery as the lung resection or very shortly thereafter to permit chemo an opportunity to be curative.

4) Further review of medical records recommended?
This is necessary to determine the likelihood of survivability of this disease had it been address appropriately rather than some nine months after its initial identification on PET scan.

System Information

Intake	104305	**Last Modified By**	Martin Ginsburg, 7/15/2016 4:10 PM

RECOMMEND ACCEPTANCE

Contact Information

Firm		**Phone Number**	
Caller Name		**Alt Phone 1**	Cellphone:
		Alt Phone 2	Cellphone:
Language	English	**Email**	
Timezone	Eastern		
Number of Attempts		**Address**	

Case Type Information

Case Type	Medical Malpractice
Information	"Charting in the Evaluation Synopsis Box Outline should be as follows: 1)RESULTING DAMAGE: List damage or none. 2)ALLEGED NEGLIGENCE: chief complaint and quick summary of incident. 3)FURTHER TREATMENT: state details of further treatment, unknown or none. 4)RELEVANT PAST MEDICAL HISTORY: list health conditions and any dx relevant to medical malpractice claim. 5)REVIEWERS NOTE: The nurses impression here. Cite if the condition or complication is common with said procedure and/or Cite any known characteristics associated with procedures or condition. *Above is the order that the information should be covered. Please use the headers provided. "

Injured Info

Verbal consent obtained	☑
Relation to Injured	Self
Name of Injured	
Injured Date of Birth	
Height	5'7"
Weight	220
Date of Injury	
US State where injury occurred	South Carolina

Nature of Injury	Injured
Married	
Dependents	

Evaluation Synopsis

Resulting Damage	Retained surgical implement
Alleged Negligence	On 1/9/2015 while visiting his daughter in SC PNC “went in” for an internal hemorrhoidectomy by Dr Surgeon (Surgeon) and was told the entire procedure would last approximately 30-40 minutes. According to records in PNC's posession “started the surgery @ 1238 ended @ 1443”. PNC advises “my son had took me in there and they told him what time to pick me up – when he came back to pick me up he had to wait out there about 2-3 hours” “asked where's my father – he was supposed to be out by now” “waited another 30-40 minutes and he asked to speak to the doctor”. PNC reports that “when I woke up they were putting my clothes on – then the wheelchair come for my son to put me in the car” “my son kept saying daddy daddy there's something wrong, what's wrong with you” “he said I aint putting you in the truck like this” “they said when he gets home he'll come around” “he asked for the doctor and the doctor said bring him back in – they put me in a room – I was sore” “they said I'm sorry Mr Wiggins but we had some complications – a needle broke off in you”. PNC was admitted to Giantscar Memorial Hospital (GMH) where “I stayed another two days in the hospital” and was told “best to leave the thing in me” “because he said it was a complicated operation because it has so many nerves around it and if they went and cut nerve I'd have to wear a colostomy bag”. PNC further reports the Surgeon “said if they went in it could do more damage than it would help” “we're going to give it another few weeks because you might pass it through your bowels”. “The doctor was telling me it hasn't moved yet” “about 6 months after the surgery the doctor said it hadn't moved” “some people get shot and it's best to leave the bullet in you”. “I had to stay in the bed for two weeks” “they were checking me every week [Xray] then every two weeks and I went there one time to an office visit and I told him how much I was hurting and he stuck a finger up me and it hurt so bad I was trembling – I liked to pass out” “ever since then I been going to the doctor and they keep checking me”. PNC reports being advised “the needle is below my hip” “in the cheek” “might be right near my hip” “I seen the Xrays and I see the hook – everybody sees the hook”. PNC further reports being told “it's time to get a specialist from out of state to try to get it out” “they don't want to take a chance they don't want to take it out”. PNC advises “today as I'm sitting on this couch I can feel it” “they put me on pain management”“I'm steady popping pills” “I can't hold my stool sometimes” “my bowel movements never been the same ever since then”.
Further Treatment	Unknown
Relevant Medical History	internal hemorrhoidectomy
Add Reviewer's Note	Retianed surgical implements are generally considered res ipsa loquitor for negligence. There is the possibility in this instance that a surgical specialist was unavailable to remove the retained object and that it was clinically indicated that a second surgery be perfromed. That acknowledged, per PNC report he was not told of the retained implement until his son had the wherewithal to refuse to take him home immediately. If a second surgery was indicated, it would have been recommended and accomplished in a timely manner. This issue, therefore, appears to sound squarely in the realm of professional negligence.

System Information

Intake	104534	**Last Modified By**	Martin Ginsburg, 8/19/2016 8:59 AM

RECOMMEND REJECTION

This matter may benefit from further investigation, however as
Presented there is insufficient information to form a substantial belief.

Contact Information

Firm		**Phone Number**	
Caller Name		**Alt Phone 1**	Cellphone:
		Alt Phone 2	Cellphone:
Language	English	**Email**	
Timezone	Eastern		
Number of Attempts		**Address**	

Case Type Information

Case Type Medical Malpractice

Information "Charting in the Evaluation Synopsis Box

Outline should be as follows:

1)RESULTING DAMAGE: List damage or none.
2)ALLEGED NEGLIGENCE: chief complaint and quick summary of incident.
3)FURTHER TREATMENT: state details of further treatment, unknown or none.
4)RELEVANT PAST MEDICAL HISTORY: list health conditions and any dx relevant to medical malpractice claim.
5)REVIEWERS NOTE: The nurses impression here. Cite if the condition or complication is common with said procedure and/or Cite any known characteristics associated with procedures or condition.
*Above is the order that the information should be covered. Please use the headers provided. "

Injured Info

Verbal consent obtained	✓
Relation to Injured	Child
Name of Injured	
Injured Date of Birth	
Height	5'3"
Weight	190
Date of Injury	
US State where injury occurred	Ohio
Nature of Injury	Injured

Married

Dependents

Evaluation Synopsis

Resulting Damage

R leg fracture - delay in diagnosis/treatment

Alleged Negligence

Per Ms. T Robbins (Caller) on 6/18/2016 Ms. K Wilkie (PNC), while a resident at Cleveland Country Place, suffered a fall from her bed during routine provision of hygiene care. As reported by Caller, nursing assistant "Michelle" was "trying to change my mom by herself and that's against the law because my mom is a "@" person patient". Michelle is reported to have turned PNC to her side for care provision and "left my mom on her side with her legs crossed, she walked out the room and shut the door, then my mom hit the floor". Caller reports being advised of the occurrence by PNC stating "she told me about it when it happened, I went upstairs and told them they needed to send her to the hospital" "told them y'all could either send her or I can call my lawyers". It was later reported to Caller that "they sent her and she had Xrays and they said everything was fine".

6/18/2016 “told me that they sent her out for an Xray (CT scan) and everything was okay. “ “they never told me” where PNC was seen for imaging.

Approximately one week later Caller reports PNC "told me 'my leg hurts'" and advising PNC that "mom you just got a little bruise" subsequently requesting Tylenol to address PNC complaint of pain.

Caller was visiting PNC on 7/2/2016 and reports swelling in the R leg. Caller insisted PNC be seen at University Hospital (UH) ED for evaluation where a R leg (?femur?) fracture was diagnosed on Xray" and PNC was admitted to UH for follow-up care. The orthopedic doctor said “based on the Xrays that they took they wasn't able to do surgery because a new bone was growing in the place where there was the fracture and if they had went in it could damage the new bone where she had the fracture”.

Further Treatment

Unknown

Relevant Medical History

cervical spine fracture with quadriplegia

Add Reviewer's Note

The complexity of this issue calls for review based upon the qualifying questions and is presented below.

1) Is there an apparent or suggested deviation in the standard of care?

Patient falls are preventable, especially in a setting such as that described here. It is difficult, at least, to envision a safe bed - with side rails up - permitting a patient's unintended fall while unattended. it is questionable as to whether OH law requires two people present during hygiene care though with quadriplegic patients this is the norm.

2) Is there a significant or permanent injury or damage attributable to the deviation?

A leg fracture, especially a femur if that is the case here, is particularly problematic as regards treatment in quadriplegic patients. Immobility for prolonged periods may result in weakened bone making it difficult to use hardware to repair and in this case, with new growth already in place a repair would likely require re-fracturing the bone to permit proper alignment. Additionally, there is the risk of lower leg blood clots and potential complications from the manipulation of the leg required for surgeries of this type.

3) Is there a direct link between the deviation and the injury or damage?

While it is remotely possible that decreased bone mass and increased bone frailty could lead to fracture under circumstances other than a fall, given the information presented and the lack of

other injuries there appears to be a linear connection between the reported fall and the injury.

4) Further review of medical records recommended?

A review of the facility records is warranted for a number of reasons:

1) An incident report should be in the file and may identify the events leading up to the PNC being found on the floor in her room as well as the witness information which may be discoverable, despite the confidentiality of QA review information in most jurisdictions;

2) There is certainly some question as to the diagnosis of the fracture and whether PNC underwent Xray studies as the facility reported to Caller;

3) In the absence of chart information related to an imaging study (Xray/CT) being conducted on 6/18/2016 if there is a finding that the fracture is displaced there is reason to suspect that further care may have exacerbated the initial injury leading to the bruising and swelling not seen until sometime after the initial fall.

System Information

Intake	104226	**Last Modified By**	Martin Ginsburg, 7/5/2016 1:08 PM