Patient Name: John H

DOB: 05/10/1943

SB Admission Date: 01/6/2018

Insurance: Medicare

Admitting Diagnosis: s/p Rt hip hemiarthroplasty

Chief Complaint: Right hip pain, muscle weakness interfering with mobility

Assessment & Plan

75 y.o. male s/p Rt hip hemiarthroplasty admitted to XX swing for rehabilitation, pain & wound management, and DVT prevention

1. Pain management with Percocet for now
2. Incentive spirometer to prevent pulmonary issues
3. DVT prophylaxis with Lovenox
4. Hypertensive disorder: Continue HCTZ. Pt notes possible cough ever since starting coreg. Will switch to amlodipine and monitor
5. Type 2 Diabetes managed with Januvia

Precautions: PWBAT on right leg

HPI

75 y.o. male who lives independently at home with wife where he plans to return to in 8-10 days. On 1/2/2018 he sustained a ground level fall from a slip on ice resulting in a right femoral neck fracture and right forearm pain trying to break his fall. Was transported to XXX Hospital where he underwent hemiarthroplasty of the right hip by Dr. A. Procedure well tolerated. Bruising on arm and forearm but no fracture. Progressed well without significant medical incident. Transferred to XX for skilled rehab. Today he denies HA, CP, palpitations, SOB, abd pain, rash, dysuria, hematuria, N/V/D/C, blood in stool. Does have mild pain involving right hip and right arm but otherwise feeling well.

MD Physical Exam

Constitutional: General Appearance: healthy-appearing and well-nourished. Level of Distress: NAD.

Psychiatric: Insight: good judgement. Mental Status: active and alert.

Head: normocephalic and atraumatic.

Eyes: Lids and Conjunctivae: non-injected. Pupils: PERRLA. EOM: EOMI.

Neck: supple.

Lungs: Respiratory effort: no dyspnea. Auscultation: no wheezing or rhonchi and breath sounds normal, good air movement, and dry rales/crackles; RLL.

Cardiovascular: Heart Auscultation: RRR and no murmurs.

Abdomen: Inspection and Palpation: soft, non-distended, and no tenderness.

Musculoskeletal: Extremities: remaining ecchymosis on right arm but no edema; Rt hip with dressing which was noted to have mild drainage; nontender, no significant swelling nor erythema surrounding the surgical incision.

Nursing and Therapy Admission Assessment and 1st 1-3 days of progress notes report as follows:

Patient lives in a 1 floor home with 2 steps to get into the house. Home has a shower in a tub.
Drives a car and likes to meet up for a morning coffee at a local restaurant with his friends at least 3 x/wk.
Neurological alert; oriented x3; cooperative; speech clear; able to communicate needs and comprehends most of what we discuss with him; pupils equal, reacts to light and accommodation (PERRLA)
BIMS assessment was completed with a total score of 15 out of possible 15
Patient able to self-report pain
Good recall of instructions overtime
Airway Management airway intact; RUL: clear; LUL: clear; RLL: diminished; LLL: diminished
Cardiovascular pulse regular rate and rhythm; peripheral pulses palpable (PPP); capillary refill less than or equal to 3 seconds; some edema to RLE
Gastrointestinal abdomen soft, nontender, nondistended; bowel sounds normoactive; no nausea and vomiting; continent, fecal; rectal tone intact; last BM: 01/05/2018
Genitourinary continent, urine; no bladder distension; urine clear pale yellow; voiding without difficulty; no vaginal discharge, redness or odor
Musculoskeletal moves all extremities (MAE); Assistance of 1 needed with RLE for mobility and requires more time to move RUE
Integumentary skin warm and dry, appropriate color for race, no S&S of DVT

Sensory Perception - ability to respond meaningfully to pressure-related discomfort: No Impairment: Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort
Nutrition - usual food intake pattern: Eats over 80% of meals.
Surgical dressing status: clean; dry; intact
Mobility:
Independent in ADLs after set up except washing and drying his back and right foot as well has some assistance needed to don pants and right footwear by holding the RLE
Bed mobility is good with the assistance of side rails but requires a staff member doing most of the work to lift and move rt leg off the bed for the patient to sit on the side of the bed as well as steadying with light support to the back. Same applies to returning to bed.
Requires set up help with walker but stands or sits independently with the assistance of the walker
Does require trunk support to lower self to the toilet as well as use of grab bar to sit on toilet and stand back up along with some assistance to pull pants back up.
Uneven surfaces, car transfer and outdoor maneuvers were not attempted on admission due to pain and safety issues re: fresh surgery
Able to walk 8-10 feet in his room once standing and 25 feet one way and return to his room with partial assistance. Able to go up and down 1 and 4 steps with assistance of the railing and constant supervision. More steps not attempted given that pt. cannot yet perform 4 steps safely.
Not able to pick up items of the floor at this time even when trying to use a reacher

Nursing and Therapy Final Assessment on day of discharge

Patient was cooperative throughout and participated in all PT & OT treatments

Pain was managed by giving Tylenol 1 hr before going to PT for the first 5 days but now rarely needed
Airway Management airway intact; lungs clear
Remaining mild edema to RLL at the end of the day but relieved with lifting feet up when sitting
Was continent of B&B through-out his stay
Surgical incision is dry, no S&Ss of inflammation. No need for a dressing.
Remained free of DVT S&Ss
Mobility:
Independent in ADLs. Using a back brush to wash his back and able to self-towel dry. Able to don shirt, pants and footwear.
Bed mobility is good with and without side rails. Able to get in and out of bed, use the toilet and ambulate 160 feet independently with the use of his walking cane.
Patient demonstrates good understanding of hip precaution and using reached as necessary without reminders.
Patient able to complete 6 steps of stairs (all that is available at the hospital) on his own using the rail.

Outdoor ambulation on tarred driveway, grass, gravel and curb without the need of cues or assistance
Patient was able to demonstrate safe car transfer (getting in & out)

Patient was discharged home on 1/15/2018 with home exercise program, OP therapy x 2/wk and medication……..