Swing Bed PI-QI Pilot Project

Scenario 2

Patient Name: Steve B

DOB: 07/7/1946

SB Admission Date: 02/1/2018

Insurance: Blue Cross

Admitting Diagnosis: S/P ischemic Left CVA with Rt. Hemiparesis

Chief Complaint: weakness, loss of balance, difficulty walking and using rt. arm

Assessment & Plan

72 y.o. African American male S/P ischemic CVA with Rt. Hemiparesis admitted to XX swing for therapy rehabilitation

Plan is to:

1. Provide PT & OT to regain functionality
2. Insulin sliding scale to manage his type 2 diabetes mellitus
3. HTN, last BP 150 / 86: will continue monitoring, and adjust medication if BP remains above ideal
4. Acute Renal impairment, improved from acute stay. Last creatinine 1.1, BUN 14: continue to monitor
5. Hypomagnesemia, last magnesium 1.5: will increase supplement to TID, and recheck tomorrow
6. Stasis dermatitis, with BLE edema: feet raised when seated- nursing to gently wash legs daily using mild liquid cleansers to help remove scaling, and apply emollient and thin layer of hydrocortisone after cleaning
7. DVT prophylaxis: will continue heparin BID for now and monitor closely
8. Continue treating hypercholesterolemia

Precautions: safety issues due to hemiparesis and lack of awareness

HPI

72 y.o. obese African American male who lives alone at home where he hopes to return within 2-3 weeks but at this time, I am unsure if that will be possible. Under the care of Dr. M. for management of his diabetes, HBP, and high CHO. Uses a walker for community outings but otherwise independent with ADLs and ambulation in his home. Admits not following his diet. Has difficulty with foot care due to obesity. On 1/26/2018 he experienced lack of balance, light headedness, weakness on Rt side. Daughter was visiting and called 911. He was transported to XXX Hospital and admitted with acute CVA. Progressed well but did develop acute renal failure which was managed without significant medical incident. Transferred to XX for skilled rehab.

MD Physical Exam

Constitutional: General Appearance: obese, admits to low activity

Psychiatric: Insight: impaired judgement regarding safety issues, some difficulty remembering

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

Cardiovascular: Heart Auscultation: RRR and no murmurs.

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

Musculoskeletal: weakness in RUE and RLE Extremities, no Hx of falls

Skin: dry scaly skin

Surgical Hx: Cholecystectomy in 2001

No Hx of falls

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

Patient lives in a 1 floor home with 4 steps to get into the house on his own. Home has a shower in a tub. Makes his own meals. Cleans house but admits not being the best kept house. Drives a car to run errands and visit grandkids at times
Neurological alert; oriented x3 to time, place and person; cooperative; speech still slightly slurred and more deliberate; able to communicate needs if given time, sometimes misses part of what we are asking of him but "gets it" given time.
Pupils equal, reacts to light and accommodation (PERRLA)
BIMS test reported as follows: was able to repeat 2 words on initial attempt, able to report the correct yr. and mo. Day of the week was based on looking at the patient communication board. Patient able to recall 3 words with cuing
Airway Management airway intact, lungs sound clear
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: 01/02/2018
Genitourinary continent, urine; no bladder distension; urine clear pale yellow; voiding without difficulty; no penal discharge, redness or odor
Musculoskeletal – limitation with RUE and RLE
Integumentary skin warm and very dry/scaly, appropriate color for race, no S&S of DVT
Sensory Perception - ability to respond meaningfully to pressure-related discomfort: Impairment: Responds to verbal commands. Has right-side sensory deficit which limits ability to feel or voice pain or discomfort
Nutrition - usual food intake pattern: Eats 100% of meals once food is cut up but requires moderate assistance with taking utensils from tray and lifting food to mouth.
ADL: Patient is unable upon admission to clean his dentures, toileting hygiene performed with max assist from staff to bring pants down and back up. Only able to complete less than ¼ of his bathing even after placed at the sink and set up.

Able to don shirt but not without cuing to start with the right side. Staff required to adjust and button the shirt. Pants are donned with helper providing more than ½ of the efforts to lift legs, pull pants up and supporting the trunk. Patient unable to don footwear.
Mobility: patient can roll to the right by pulling his body with the bedside rail but requires assistance of 2 to turn to the left. Requires max assist from 1 staff member to hold trunk to sit in bed from lying position and to lie back down. Requires assistance of 2 to go from bed to standing but assistance of 1 with substantial effort to go from sitting in chair to standing. Patient assists by supporting his left side on walker. Same goes for assistance needed to sit on toilet or get back up with max assist of 1 and use of grab bar on the left. Requires assistance of 2 with max effort to return to bed from chair.
Stairs, car transfer and outdoor maneuvers were not attempted on admission due to mobility and safety issues.
Able to walk in room only from bed to bathroom and staff using gait belt while providing more than ½ the effort. Walking in corridor or gym was not attempted do to still being too unsafe for such an activity.
Not able to pick up items of the floor at this time.
Patient has a manual wheelchair but fully dependent on the staff to maneuver it.

Nursing and Therapy Final Assessment on day of discharge

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

Pain was not an issue during this IP stay.
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
Remained free of DVT S&Ss
Dietician worked with patient to reinforce diabetic diet and nursing reinforced skin and foot care
Able to prepare 2-3 step light snack with supervision but not yet able to provide his own meals.
Mobility:
Able to eat independently once set up.
Patient continues to require assistance with meal plan and skin/foot care.

Requires set up for oral hygiene and continued supervision for bathing and dressing. Able to use toilet with use of grab bar – can pull pants down and back up without assistance.
Safely uses reacher to pick items from the floor
Bed mobility has improved to being independent with use of bedside rail. Able to get in and out of bed with assistance of bedside rails. Can sit to stand using his walker for support.
Uses walker in room but manual wheelchair is required for longer distance in corridor and community which he maneuvers by himself up to 50 ft. but requires moderate assistance for longer distance.
Able to transfer in & out of a car with partial to moderate assistance from staff depending on how tired he is.
Able to go up and down 4 steps with railing and assistance. Now slightly provides more than ½ the assistance required.
Can walk 10 feet on even flat surface with stand-by assist and maneuver 1 step curb with contact guard

Patient was discharged to an Ast. Living on 1/23/2018 with home health for diabetes and BP monitoring & management as well as continued therapy.