Swing Bed PI-QI Pilot Project

(Modified Scenario 3 sufficient to assess participant's other coding skills)

Patient Name: Susie C

DOB: 09/15/1925

SB Admission Date: 03/26/2018

Insurance: Medicare Advantage

Admitting Diagnosis: multiple decubitus ulcer, post-acute episode of A Fib and CHF

Chief Complaint: patient unable to verbalize complaints

Assessment & Plan

93 y.o. white female with multiple state 3 and 4 decubitus ulcers admitted to XX swing for wound management, and continued monitoring and treatment of A Fib and CHF along with reassessment of a discharge plan

1. Referral to wound management team for treatment recommendation and follow-up
2. Telemetry to monitor for more episode of A Fib and manage as appropriate
3. Continue monitoring CHF and treatment
4. History of CAD
5. History of fractured hip from a fall and hemiarthroplasty of the left hip 10 years ago

Precautions: No specific

HPI

93 y.o. frail white female who lives with her unemployed son in her home. Patient is malnourished, bed-ridden for most of the past 10 yrs. Son had refused referral

to a nursing home and home health. Presence of 4 deep coccyx area and buttocks wounds. Was brought to ED by ambulance to XX Hospital on 2/22/18 due to episode of “difficulty breathing” as noted by son. Patient was admitted with A Fib and CHF which was stabilized during the acute stay. Also admitted with dehydration which was managed with IV fluids. Now being transferred to skilled care for continued assessment and management of A Fib and CHF along with wound management and potential PEG insertion post intake assessment. Attempts will be made to discharge to a NH vs returning home.

MD Physical Exam (partial)

Constitutional: General Appearance: unhealthy emaciated mal-nourished.

Psychiatric: Insight: mostly non-responsive

NECK: neck is stiff with limited ROM

RESPIRATORY: shallow breathing, wheezing, bilateral crackles in both lower lobes

CARDIOVASCULAR: some irregular rhythm – telemetry showing intermittent PACs and PVCs

ABDOMEN: abdomen is distended, hard to palpation in all quadrants.

No notation of last bowel movement

Musculoskeletal: moderate to severe contractions in all 4 extremities

Fall HX – son denies any falls

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

Patient lives in a 2- floor home with 6 steps to get into the house. Patient’s bedroom is on the 2nd floor. Patient has been mostly bedridden since her hip

fracture 10 years ago. Son has been caring for his mom for 10 years almost full time.
Neurological alert; non-responsive, cannot communicate, does respond to food put on her lips and can swallow pureed foods her son prepared.
Patient unable to self-report pain but does wince when her position is changed in bed or ROM is attempted. Does respond to face being stroked.
Gastrointestinal abdomen hard, distended; bowel sounds are limited, question of fecal impaction. Son states she is incontinent of bowel – usually gives her enemas
Genitourinary: incontinent of urine; no bladder distension; concentrated color
Musculoskeletal: unable to move any extremities, patient in fetal position.
Patient is totally dependent for all ADLs and change of position. Bedbound and chairfast.
Integumentary skin cool and dry, appropriate color for race
Presence of 4 pressure ulcers; 1 at level 3, 2 at level 4 and 1 unstageable due to eschar tissue
Sensory Perception – unable to respond meaningfully to pressure-related discomfort
Nutrition – responds to being fed pureed food but takes less than 50% of calorie intake.
A PEG tube was inserted on 4/1 – procedure well tolerated

Nursing and Therapy Final Assessment on day of discharge

No change in patient demeanor during her stay on the skilled unit

Pain was managed by giving Tylenol suppository before assessing for ROM to determine methods to improve positioning.
Airway Management- airway intact; lungs clear but shallow breathing
Was incontinent of B&B throughout her stay
ADLs and mobility were not attempted given her pre-admission status
A Fib and CHF were managed during her stay without complication
Dr Z performed surgical wound debridement during her stay followed by wound vac treatment. At discharge, wounds are clean, not infected and improving …….
Patient receiving calories as recommended using tube feeding which continued to be well tolerated until discharge.
Physician and team were able to convince the son to refer the patient for continued wound management in a NH.

Patient was discharged to CCC Nursing Home SNF unit on 4/16/2018 for continued wound management, tube feeding and custodial care with the long-term goal to remain in LTC post SNF days.