Home Health Virtual Training Program–Part 1

CASE STUDY NARRATIVE

Recent Medical History

Mr. P. is a 68-year-old male who was admitted to an acute care hospital on June 2, 2022, after a fall. He reported becoming dizzy and falling while working in his garden. His neighbor called 911 and he was taken to the emergency department. Upon admission, he was diagnosed with an embolic cerebral infarction, dysphagia, and right-sided weakness. His COVID-19 test was negative upon admission to the hospital.

Mr. P.'s past medical history includes being a former cigarette smoker (quitting 10 years ago), hypertension, obstructive sleep apnea requiring the use of a continuous positive airway pressure (CPAP) machine, major depressive disorder, atrial fibrillation, an embolic cerebral vascular accident 3 years ago, and chronic back pain.

During the acute care hospitalization, Mr. P. was started on intravenous (IV) anticoagulant therapy and IV fluids to treat dehydration via peripheral IV access. His hospital stay was complicated by an episode of rapid atrial fibrillation, requiring cardioversion and medication intervention. Due to a low oxygen saturation level, Mr. P. was placed on oxygen therapy at 2 liters per minute continuously. The fall prior to admission aggravated his chronic back pain, and after a Pain Team consult, Mr. P.'s pain medication regimen was adjusted. A speech therapy evaluation and swallow study were performed, and Mr. P. was subsequently placed on a heart-healthy, mechanical soft diet with nectar-thick liquids due to dysphagia. Mr. P. was noted to have right-sided weakness in both his upper and lower extremities. An inpatient physical therapy (PT) evaluation was completed, recommending PT and occupational therapy (OT) services for strengthening and mobility training, and evaluation of chronic pain. A few days after admission, Mr. P. was transitioned to an oral anticoagulant. On June 7, 2022, his supplemental IV hydration was discontinued due to improved oral intake and resolution of dehydration. Mr. P. was trialed on room air during the last several days of his acute care hospital stay, but he demonstrated desaturation with physical activity. As a result, the order for continuous oxygen was changed to use as needed for shortness of breath and during physical activity to maintain an oxygen saturation greater than 90 percent.

Mr. P. was discharged from acute care on June 9, 2022. He was referred to home health services for medication teaching/management; anticoagulation instruction/monitoring; assessment of need for supplemental oxygen; pain management; evaluations for physical, speech, and occupational therapy; and diet instruction.

Excerpt From the Home Health (HH) Start of Care (SOC) Assessment

At the SOC assessment on June 10, 2022, Mr. P. is noted to be wearing a hearing aid and states he can hear normal conversation when using it. However, without his hearing aid he has moderate difficulty hearing. Mr. P. reports that he does not use corrective lenses and it is difficult for him to see regular-sized print; the print must be enlarged for him to be able to read it. The nurse verifies his visual ability by having him read the large headlines in a newspaper aloud.

When asked how often he needs to have someone help him when he reads instructions from his physician or pharmacy, Mr. P. stated that it is sometimes helpful to have someone explain the written instructions that the physician has provided him.

Mr. P. states that his ethnicity is not of Hispanic, Latino, or Spanish origin. He indicates that he identifies as both African American and Filipino. He speaks Spanish but prefers conversing in English and declines the need for an interpreter. Mr. P. reports that he lives alone in a small home and does not drive. His closest relative is his retired

daughter who lives about an hour away. She brought him home from the hospital yesterday and will be staying with him for a while until he is safe to live alone. Mr. P. stated that over the last 6–12 months he sometimes had trouble getting transportation to the senior center and occasionally missed medical appointments. He has a neighbor who can help, but is not consistently available to provide transportation to appointments.

Mr. P. reports that his usual diet at home is regular food with no restrictions and expressed concern about the heart-healthy, mechanical soft diet with nectar-thick liquids. The nurse reviewed the written nutritional resources provided by the hospital dietician with both Mr. P. and his daughter, and provided nutritional counseling to help Mr. P. identify the correct foods to prepare at home.

In addition to the dysphagia, Mr. P. presents with some mild weakness in the right upper extremity and moderate weakness in the right lower extremity, requiring the use of a walker. He can perform most of his activities of daily living but requires partial/moderate assistance with bathing and dressing. Mr. P.'s cardiac status is stable and atrial fibrillation is well controlled with a regular heart rate in the 60s. Mr. P.'s gastrointestinal, behavioral/cognitive, and integumentary assessments were unremarkable. He is using oxygen via nasal cannula at 2 liters per minute for short periods of time throughout the day when short of breath or with any physical activity to maintain his oxygen saturation greater than 90 percent.

At SOC, Mr. P. reports a history of chronic back pain and stiffness that was aggravated by the recent fall. He rates his current pain as a level 4 out of 10 on the pain scale, describing it as "dull and achy." Mr. P. states that he takes two acetaminophen each morning to control his chronic back pain, allowing him to perform his normal activities of daily living, and that this pain only occasionally limits his daily activity. He notes that this has been the case over the past 5 days as well. Mr. P. reports that since the stroke, he has been experiencing muscle spasms in his right leg. He states that the spasms have improved since the beginning of his acute care hospital stay, but still frequently wake him up at night. Mr. P. reports that he takes baclofen to help manage this leg spasm pain. Mr. P. also reports that in the hospital he was seen by a physical therapist, who worked with the Pain Team to establish a pain management plan using tramadol to allow him to participate in the physical therapy exercises. The plan has been effective, and over the past 5 days Mr. P. reports only occasionally experiencing pain during his physical therapy exercise sessions that limits his participation.

Excerpt From the Physician Referral and Orders

At SOC, Mr. P. reports being allergic to sulfa drugs and strawberries. The following medications have been ordered for Mr. P.:

- Lisinopril, 10 mg by mouth daily for hypertension.
- Metoprolol tartrate, 50 mg by mouth twice a day for atrial fibrillation.
- Acetaminophen, 500 mg by mouth every 6 hours as needed for mild pain (pre-medicate prior to therapy).
- Venlafaxine hydrochloride, 75 mg by mouth daily for major depressive disorder.
- Warfarin sodium, 5 mg by mouth daily on Tuesday and Thursday to prevent thromboembolic complications associated with atrial fibrillation.
- Warfarin sodium, 7.5 mg by mouth daily on Sunday, Monday, Wednesday, Friday, and Saturday to prevent thromboembolic complications associated with atrial fibrillation.

- Baclofen, 20 mg by mouth each night for muscle spasms.
- Tramadol, 50 mg by mouth every 12 hours as needed for back pain greater than 8/10.
- Oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath and with any physical activity to maintain oxygen saturation greater than 90 percent.
- CPAP therapy on room air at bedtime and during naps.

Mr. P. is also ordered to have physical, occupational, and speech therapy evaluations. He will remain on a heart-healthy, mechanical soft diet with nectar-thick liquids due to dysphagia. Pain management instruction, medication teaching/management and anticoagulation monitoring, diet and post-stroke instruction, and assessment of the need for supplemental oxygen are to be provided. The HH nurse will also check his prothrombin time (PT)/international normalized ratio (INR) on each visit as ordered by the physician. The goal is to maintain the INR within a 2.0 to 3.0 therapeutic range. He will continue to use oxygen at 2 liters per minute via nasal cannula as needed for shortness of breath and with any physical activity to maintain oxygen saturation greater than 90 percent.

HH Nursing Progress Note

After admission to HH services, Mr. P. continued to experience leg and back pain. He was taking acetaminophen as needed, baclofen at night, and tramadol for any breakthrough pain. Mr. P. complained of dizziness and headache related to the tramadol and it was discontinued on June 12, 2022, with effective resolution of these symptoms. His pain was well managed with the remaining analgesic orders.

Skilled nursing continued to monitor Mr. P.'s INR levels as ordered. Three days after admission to HH services, his INR level increased to 7.3 and he was noted to have hematuria. After consultation with his cardiologist, Mr. P.'s medication regimen was changed and on June 14, 2022, the warfarin sodium was discontinued. Apixaban, 5mg by mouth twice per day, was ordered to prevent thromboembolic complications associated with atrial fibrillation. A swallow study was ordered and performed at the recommendation of the speech-language pathologist on June 17, 2022. Based on the results of the study and improvement in his clinical status, Mr. P.'s diet was advanced to a regular consistency, heart-healthy diet on June 19, 2022, with no further need for thickened liquids. Speech therapy was discontinued on June 20, 2022. Mr. P. continued to require education and reinforcement in making appropriate dietary choices, admitting that he prefers salty foods but would like to learn more about healthy ways to make his food more flavorful.

During his HH episode of care, Mr. P. received PT and OT services, with ongoing functional progress noted. On June 20, 2022, he transitioned to a quad cane and now requires steadying assistance and contact guard with bathing and dressing. As he is still not at his prior level of function, PT and OT services continue to be required to increase strength and endurance. PT evaluated Mr. P.'s pulse oximetry during physical activity throughout his episode of care. The therapist and nurse both documented that his oxygen saturation was maintained at greater than 90 percent on room air during physical activity for over a week. There were no episodes of shortness of breath at rest noted since SOC. On June 23, 2022, his physician was contacted and the oxygen was discontinued. Mr. P.'s respiratory status remained stable for the duration of the HH episode of care.

Medication instruction was provided throughout the HH episode with reinforcement and teach-back evaluation. Mr. P. initially had difficulty remembering the two new doses of apixaban, so his nurse set up a medication box and taught

Mr. P. how to fill it to help promote adherence. Through teach-back evaluation, Mr. P. demonstrated competence in pre-filling his medication box and is now successful in independently managing his medications.

Excerpt From the HH Nursing Discharge Note

Throughout the HH episode of care, Mr. P. did not have any signs of increased temperature or infections and his weight remained at 135 pounds. He remained on a regular-consistency, heart-healthy diet. Mr. P. maintained a normal blood pressure and his cardiac status was stable. His gastrointestinal, elimination, behavioral/cognitive, and integumentary assessments were unremarkable. Mr. P. continues to use his CPAP machine on room air at night and during naps and manages this equipment without assistance.

Mr. P. reports that he no longer experiences muscle spasms in his right leg but has continued to experience back pain that affects his sleep occasionally. The pain that had affected his day-to-day activities is now effectively managed with only acetaminophen and it no longer interferes with his participation. The baclofen has been discontinued. Mr. P. has made progress with his strength and endurance as a result of PT and OT services. He reports that the pain he was experiencing that interfered with his participation in PT sessions is no longer present. He still requires a quad cane for ambulation and needs steadying assistance from his daughter to dress and bathe. He was discharged from PT on June 28, 2022, and OT on June 29, 2022, after meeting the established therapy goals.

Mr. P. reports that he sometimes has difficulty understanding the written dietary instructions regarding sodium that were provided to him and requires additional help to understand this material. The nurse reviewed this information with Mr. P. and his daughter and confirmed their understanding. Mr. P.'s daughter will be supporting medication management and meal planning after HH discharge.

Reconciled discharge medication profile:

- Apixaban, 5mg by mouth twice a day to prevent thromboembolic complications associated with atrial fibrillation.
- Lisinopril, 10 mg by mouth daily for hypertension.
- Metoprolol tartrate, 50 mg by mouth twice a day for atrial fibrillation.
- Acetaminophen, 500 mg by mouth every 6 hours as needed for mild pain (pre-medicate prior to therapy).
- Venlafaxine hydrochloride, 75 mg by mouth daily for major depressive disorder.

Mr. P. has been provided with his reconciled written medication list in large-type font and was instructed on his medication regimen using this list. He asked that a copy of his medication list be provided to his daughter also. When Mr. P. was asked whether lack of transportation has kept him from medical appointments, meetings, work, or from getting things needed for daily living, he stated that this has been a problem for both medical and non-medical appointments in the past 6 months to a year. However, he reports that since his daughter's arrival, she has been providing transportation to doctors' appointments. His daughter will also obtain his medication from the pharmacy and grocery shop for him. During the episode of care, Mr. P.'s daughter worked with the nurse to explore community transportation alternatives and arranged transportation services for her father after she returns home. The nurse sent a fax copy of the reconciled medication list with the final discharge summary to Mr. P.'s physician.

Mr. P. was discharged from HH services on July 1, 2022.