Inpatient Rehabilitation Facility (IRF) Quality Reporting Program (QRP) Training Case Study

Mrs. G is an 81-year-old female, (right-hand dominant) who lives alone and continues to work on a part-time basis at the family store managing the finances. When she did not arrive for work on July 6, 2016, her family became concerned and went to her home to check on her. Mrs. G's daughter found Mrs. G lying on her left side on the bedroom floor in the same clothes she wore the previous day, indicating she had been on the floor overnight. She was attempting to get up, but she was having difficulty moving her right arm and leg. She was attempting to tell her daughter what happened, but she was having a difficult time finishing her thoughts. Her daughter called 911, and Mrs. G was taken to the Emergency Department of her local acute care hospital. An MRI of her head confirmed the diagnosis of a stroke resulting in right-sided weakness. Mrs. G was admitted to acute care and treated according to stroke protocol. The Neurologist recommended anticoagulation with warfarin with a transition to Xarelto after 1 month. Her hypertension was controlled with diltiazem and metoprolol. At the time of her assessment in the Emergency Department, Mrs. G was noted to have in intact 0.5 cm wide by 3 cm long purple area of her left hip and a 2 cm round reddened non-blanchable area on her left scapula. These were assessed as a suspected deep tissue injury and a Stage 1 pressure ulcer, respectively. She was also noted to have multiple skin tears and bruising on her arms. On July 7, 2016, Physical, Occupational, and Speech Therapy evaluations were completed. Recommendations from therapy were that Mrs. G transition to acute rehabilitation for continued intensive therapy upon discharge from acute care. Mrs. G's past medical history includes hypertension, diabetes mellitus, hypothyroidism, colon cancer, and cataracts. Her past surgical history includes a recent colon resection on May 26, 2016. Mrs. G was cleared for discharge from the acute care hospital and was admitted to Forest Hills Inpatient Rehabilitation Facility (IRF) for acute rehabilitation on July 8, 2016.

Prior Level of Function

Mrs. G lives alone in a two-level home. Her bedroom and bathroom are on the second level. Prior to the stroke, Mrs. G was independent in activities of daily living (ADL) and instrumental activities of daily living (IADL) performance. She did not use a device for in-home or outdoor ambulation nor in using the home's internal or external stairs. Mrs. G enjoys working at the family store managing the finances and spending time with her five grown children, who live nearby.

Excerpt From the Admission Nursing Assessment

Mrs. G's admission nursing assessment was completed on July 8, 2016. At the time of the assessment, she was alert and oriented to person and place but was unsure of what day of the week or time of day it was. Her speech was clear, but she had difficulty finishing thoughts and finding words periodically throughout the assessment. Mrs. J wears full upper and lower dentures, glasses for reading, and a left hearing aid. Her daughter, who was present at the time of her admission assessment, brought these items from Mrs. G's home. Mrs. G denied pain but moaned loudly when the nurse assisted her to turn side to side for her skin assessment and yelled the word "shoulder." When this occurred, the nurse again asked Mrs. G about pain, and Mrs. G was provided with pain medication for pain that she rated as 7 on a scale of 0–10. Her skin assessment revealed that she had a 6 cm wide by 4 cm high deep purple intact area over her left

hip and a 2 cm round reddened area on her left scapula with a 1 cm serum-filled blister in the center of the reddened area. These were assessed as a suspected deep tissue injury and a Stage 2 pressure ulcer, respectively. Mrs. G's daughter reported that she had full control of her bowels but dribbles urine several times a day when she coughs, bends over, or otherwise strains. She wears disposable, absorptive undergarments to manage this. Mrs. G's daughter stated that she has not had any other falls in the last year except the one when she had her stroke. Mrs. G is on a pureed diet with nectar thick liquids.

Excerpt From the Physical Therapy Evaluation

- Rolling (left and right): Mrs. G reaches for bed rail with left hand when rolling to the right. She is unable to assist with rolling to the left side and then on to her back. The therapist provided more than half of the effort.
- Sit to Supine: Mrs. G required assistance of the therapist to lift her right leg back into bed as well as support her trunk. Mrs. G was able to bring her left leg into the bed.
- Supine to Sit on Side of Bed: Mrs. G was able to bring her left leg off the bed and assist with pushing up with her left arm. She required maximum assistance to bring her right leg off of the side of the bed and needed to be supported by the therapist to come to a sitting position.
- Sit to Stand: Mrs. G was able to come to a standing position with maximum assistance of the therapist. Once standing, the patient used the hemi-walker to steady herself. Using a gait belt, the therapist had to provide maximum assistance to lift and support Mrs. G in order for her to come to a standing position.
- Bed-to-Chair Transfer: Mrs. G required maximum assistance from the therapist to pivot transfer to a wheelchair. In addition to providing physical assistance with the transfer, Mrs. G needed the therapist to position the hemi-walker prior to and during the transfer and provide verbal cues. Using a gait belt, the therapist lifted and supported the patent during the transfer.
- Car Transfer: Not tested at this time due to safety concerns. Anticipate that Mrs. G will be able to transfer into a car at discharge.
- Ambulation: Not tested at this time due to safety concerns. Anticipate Mrs. G will be ambulatory at discharge.
- Stairs: Not tested at this time due to safety concerns. Anticipate that Mrs. G will complete a flight of stairs prior to discharge.
- Wheelchair Mobility (Short Distance): In a standard wheelchair with a right footrest, Mrs. G was able to wheel 50 feet with verbal cues to use her left foot and left arm to propel forward. She required touching assistance to perform two turns.
- Wheelchair Mobility (Long Distance): With verbal cues, Mrs. G was able to propel herself 150 feet using a standard wheelchair with a right footrest.

Physical Therapy Discharge Goals

1. Patient will be independent with bed mobility, including rolling left and right, moving from a sitting to supine position and vice versa utilizing the bed rails.
2. Patient will sit to stand with contact-guard assistance with the use of a hemi-walker.
3. Patient will complete bed-to-chair transfers with contact-guard assistance with the use of a hemi-walker.
4. Patient will complete car transfers with contact-guard assistance for steadying.
5. Patient will walk 150 feet with contact-guard assistance with the use of a hemi-walker.
6. Patient will walk 50 feet completing two turns with the use of a hemi-walker and a helper providing less than half of the effort.
7. Patient will walk 10 feet with contact-guard assistance with the use of a hemi-walker.
8. Patient will walk 10 feet on uneven surfaces outdoors with the use of a hemi-walker and a helper providing less than half of the effort.
9. Patient will complete 1 step, 4 steps, and 1 flight of stairs (12 steps) with a helper providing less than half of the effort.
10. Patient will complete object retrieval activity from a bending or stooping position, independently after setup of adaptive equipment.
11. Patient will not require a wheelchair on discharge; however, should she choose to use one, Mrs. G will be capable of independently propelling a standard wheelchair 50 feet with two turns and 150 feet.

Excerpt From the Occupational Therapy Evaluation

- Eating: Mrs. G was able to feed herself with her non-dominant hand after staff opened her containers. Mrs. G required constant verbal cues to alternate liquids and solids during meals.
- Oral Care: Mrs. G was able to remove her dentures from her mouth, rinse them, and place them in the cup to soak. After mouthwash was opened for her, she was able to pour it into a cup and rinse her mouth independently. She was able to remove the dentures from soaking and rinse them but required assistance to open the tube of denture adhesive. She was able to independently apply the denture adhesive and place her dentures back in her mouth.
- Toilet Transfer: Mrs. G transferred on and off the toilet with maximum assistance of the therapist and the use of a hemi-walker.
- Toileting Hygiene: Mrs. G was able to perform her own perineal hygiene after supplies were set up for her. She required the assistance of two staff members to manage her disposable undergarment and pull her pants and underwear up and down.

- Shower/Bathe Self: Mrs. G transferred with maximum assistance of the therapist onto a shower chair to complete her bathing. Mrs. G was able to wash, rinse, and dry her face, right arm, chest, abdomen, and anterior thighs. The therapist assisted with all other parts of her body.
- Upper Body Dressing: Mrs. G was able to thread her right arm into her shirt. The therapist needed to thread her left arm. Mrs. G pulled the shirt over her head and adjusted it. Mrs. G did not wear a bra on evaluation.
- Lower Body Dressing and Footwear: Mrs. G required the therapist's assistance to don her pants and underpants. She then needed assistance of one staff member to pull her elastic-waist pants and underwear up and down. The therapist needed to put Mrs. G's socks and shoes on for her.

Occupational Therapy Discharge Goals

1. Patient will independently set up and eat meals and snacks.
2. Patient will independently complete her oral care.
3. Patient will complete toilet transfers with contact-guard assistance using a hemi-walker.
4. Patient will complete toilet hygiene with contact-guard assistance.
5. Patient will complete bathing seated on a shower chair with supervision for safety.
6. Patient will complete upper body dressing with supervision.
7. Patient will complete lower body dressing with a helper providing less than half of the effort.
8. Patient will don/doff socks and shoes with a helper providing less than half of the effort.

Additional Notes

On July 9, Mrs. G was transferring to bed with a nursing assistant when she lost her balance to her right side. The nursing assistant lowered Mrs. G to the floor. Upon evaluation by the nurse, Mrs. G had moaned in pain when her right ankle was palpated. An x-ray was taken and was negative for a fracture. Mrs. G was diagnosed with a sprained right ankle and placed in an air splint for comfort. An acetaminophen was ordered as needed for pain.

On July 11, the previously noted suspected deep tissue injury over her left hip was assessed and noted to have evolved to a full-thickness Stage 3 pressure ulcer. There is no bone, tendon, or muscle visible. The area's measurements are as follows: length of 2 cm, width of 3 cm, and depth of 0.4 cm. The Stage 2 pressure ulcer on her left scapula was assessed and determined to have healed on July 25.

On July 19, Mrs. G no longer had pain in her right ankle. The air splint and acetaminophen were discontinued by the physician.

Discharge

Mrs. G progressed nicely toward her goals, and she was discharged to home on August 1, 2016. Her children set up a schedule to stay with her at all times and to assist with her care at home. At that time, the Stage 3 pressure ulcer over her left hip was markedly improved but remained unhealed. Its measurements were as follows: length of 0.5 cm, width of 1.3 cm, and depth of 0.2 cm. A referral for skilled home healthcare services was made, with skilled nursing ordered for her pressure ulcer treatment and physical therapy for continued therapy at home.

Therapy discharge summaries stated her functional status was as follows:

- Eating: Independent.
- Oral Care: Independent.
- Toilet Hygiene: Contact Guard.
- Shower: Supervision for safety with showers while seated using a foam back brush to clean her back.
- Upper Body Dressing: Supervision.
- Lower Body Dressing: Mrs. G performs more than half of the effort.
- Donning/Doffing Socks and Shoes: Mrs. G performs more than half of the effort.
- Rolling Side to Side in Bed: Independent with use of bed rails.
- Supine to Sit: Supervision.
- Sit to Supine: Supervision.
- Sit to Stand: Contact-guard assistance with hemi-walker.
- Bed-to-Chair Transfer: Contact-guard assistance with hemi-walker.
- Toilet Transfer: Contact-guard assistance with hemi-walker.
- Car Transfer: Able to get in and out of a car with contact-guard assistance for steadying.
- Ambulation: Walks 150 feet, 50 feet with two turns, and 10 feet with contact-guard assistance with the use of a hemi-walker. A helper provides less than half of the effort for walking 10 feet on outdoor uneven surface with use of a hemi-walker.
- Stairs: Mrs. G performs more than half of the effort for completing 1 step, 4 steps, and 1 flight (12 steps).
- Object Retrieval: Independent after setup of adaptive equipment to complete picking up an object at ground level.
- Wheelchair Mobility: The patient does not require a wheelchair, but her daughter has purchased a manual wheelchair for her mother to use as needed for outings. The patient is able to independently propel the wheelchair 150 feet and 50 feet with two turns.