

## Home Health Quality Reporting Program (QRP) Training Case Study

**Recent Medical History:** Mr. B is a 72-year-old Caucasian male who lives with his wife in a two-story, single-family home. Nine months ago, he underwent a right below-the-knee amputation (BKA) due to diabetic complications and peripheral vascular disease (PVD). He is independent with his new prosthesis, which he received 4 months ago.

### **Hospital Discharge Summary:**

While visiting friends out of town, Mr. B fell, injured his left wrist and his back, and was transported emergently to the local acute-care hospital. His left wrist x-ray was negative for fracture and was determined to have a ligament strain. His wrist was wrapped with a splint for immobilization and support.

During his hospitalization, he demonstrated confusion and became acutely agitated. Providers suspected alcohol withdrawal based on reviewing his past medical history. He was intubated for airway protection for 3 days and was noted to have weakness and numbness in his lower left extremity. The patient's blood cultures were positive for methicillin-sensitive *staphylococcus aureus* (MSSA) bacteremia, and his sputum cultures were positive for *E. coli*. He was treated with cefazolin and levofloxacin. A repeat MRI revealed a fluid collection in Mr. B's spinal canal, which was suspicious for hematoma and the possible source of the bacteremia. This was the likely cause of his back pain. During the hospitalization, Mr. B also developed a Stage 3 pressure ulcer on his sacrum measuring 3 cm × 4 cm × 0.6 cm. Upon discharge, the pressure ulcer was presenting with granulation tissue measuring 2 cm × 2 cm × <1 cm.

Mr. B suffered acute kidney injury and elevated liver function tests from alcoholic hepatitis. The splint was removed on his left wrist, and an ace bandage was applied for support. He was discharged with the following diagnoses: Stage 3 sacral pressure ulcer, epidural abscess, MSSA bacteremia, hepatic encephalopathy, alcohol withdrawal, right BKA, hypertension, type 2 diabetes mellitus, peripheral neuropathy, PVD, lower left extremity weakness, and left wrist strain. He was discharged on a diabetic diet. Vital signs upon discharge were as follows: BP 135/92, P 78, RR 20, O<sub>2</sub> 98 percent on room air, pain scale score 4 out of 10.

### **Physical Therapy Discharge Summary:**

- Mr. B requires assist of one from sit to stand with lower extremity prosthesis on.
- Mr. B requires assist of one to stand pivot transfer to chair.
- Mr. B is able to ambulate 75 feet with contact guard, prosthesis applied, and a walker with a left platform attachment.

### **Occupational Therapy Summary:**

- Mr. B requires setup and minimum to moderate assistance for all personal care activities.
- Mr. B requires setup and minimum to moderate assistance to apply his prosthesis due to left wrist strain.
- Mr. B requires setup for meals, but he can independently feed himself.

**Prior Level of Function:** Prior to the acute care admission, Mr. B was independent for all activities of daily living (ADLs), was able to apply his prosthesis independently, and used a cane while walking.

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### **Excerpt From the Home Health Agency (HHA) Nursing Start of Care Comprehensive Assessment:**

The home care agency received a referral for nursing, physical and occupational therapies, and home health aide services for Mr. B, who returned home following a 4-week acute-care hospital stay. The nurse called Mr. B in the afternoon on the day of discharge to inform him of her planned visit for 9 a.m. the next morning. She asked Mr. B to stay in bed so that she could start his assessment there, and he agreed. When the nurse arrived the following morning, she found Mr. B in bed, alert and oriented. His vital signs were as follows: BP 140/90, P 82, RR 18, and O<sub>2</sub> 99 percent on room air.

Upon further assessment, the nurse noted that Mr. B's speech was clear, but he had difficulty finishing thoughts and occasionally finding words. Mr. B uses glasses for reading but frequently refuses to wear them. His wife, who was present during the admission, brought his eyeglasses to him. The patient reported a pain scale score of 4 out of 10, most intense in the lower back area, which increased to a pain score of 6 with movement and turning. His wrist pain was reported as 3 out of 10 on the pain scale.

His lower left extremity was cool to the touch with little hair noted and a weak pedal pulse. His leg weakness had subsided, but numbness persisted. Mr. B reported that he normally has control of his bowels and urination, but over the last week had experienced frequent loose stools. On two occasions he did not make it to the bathroom in time. He stated that he needs help with ADLs. During the skin assessment, the nurse noted the perianal area was irritated with residual dry stool present. Also noted was a pressure ulcer on the sacrum that was pink, with no observed slough, and measured 2 cm × 2 cm × <1 cm.

The nurse noted that Mr. B is right-handed and had a table on the right side of his bed where he kept his prosthesis. She asked permission to weigh the prosthesis and his shoes prior to Mr. B putting the prosthesis on, in anticipation of obtaining his weight later in the assessment. After weighing the prosthesis and shoes, the nurse placed the prosthesis back on the table by the bed. Due to safety concerns, Mr. B's height was measured while lying flat in bed, using the longer lower extremity, per agency policy. Mr. B's height was recorded as 69.5 inches.

In the nurse's clinical judgment, it was safe to have Mr. B attempt the lying-to-sitting activity. Because of his left wrist strain, it was necessary for Mr. B's wife to help steady him by supporting his trunk. He moved his legs over the edge of the bed, and his wife provided less than half of the effort by supporting his trunk to the sitting position. Mr. B was able to sit on the side of the bed safely, without assistance, with his left foot on the floor and his right BKA stump not touching the floor. Once seated safely on the side of the bed, Mr. B lifted the prosthesis with his right hand and positioned it on the floor. With minimal assistance from his wife, Mr. B secured his prosthesis and donned his left shoe. In collaboration with Mr. B and his wife, and considering Mr. B's improving wrist, prior mobility status, and motivation to improve, the nurse determined that Mr. B is expected to perform the activity of lying to sitting on side of the bed independently by discharge. The patient was able to stand and was observed to safely ambulate with a walker to the door of his bedroom. The nurse noted that Mr. B demonstrated slight dyspnea upon exertion during this activity.

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The nurse weighed Mr. B according to agency policy. This included using an agency-provided scale to obtain Mr. B's weight while wearing shoes with his prosthesis. She then subtracted the weight of the prosthesis and shoes from Mr. B's recorded weight. The nurse documented his weight as 220.3 pounds.

Mr. B is prescribed a diabetic diet. His wife stated that Mr. B has been diabetic and requiring insulin for 15 years. He was able to self-administer his insulin without difficulty. However, Mr. B now requires assistance with blood glucose monitoring and insulin administration due to his wrist injury. His wife assists with management of the sliding scale. The nurse performed the depression screening using the appropriate agency-accepted tool and determined that Mr. B has risk factors at this time.

The nurse completed the medication reconciliation using the acute care discharge orders. Mr. B does not have any known drug allergies.

Insulin orders are:

- Regular Insulin twice a day:
  - BS 131–180: give 2 units.
  - BS 181–240: give 4 units.
  - BS 241–300: give 6 units.
  - BS 301–350: give 8 units.
  - BS 351–400: give 10 units and call MD immediately.
- Lantus 20 units daily at bedtime.

Oral medications include the following:

- Lisinopril 10 mg daily.
- Gabapentin 600 mg three times a day.
- Lactulose 1 tablespoon of 10 g/15 ml three times a day.
- Hydrochlorothiazide 25 mg daily.
- Oxycodone immediate release 10 mg every 4 to 6 hours as needed for moderate to severe pain.
- Diclofenac sodium 50 mg every 8 hours as needed for mild to moderate pain.
- Paroxetine 20 mg daily.

Mr. B showed the nurse a bottle of medication and stated that he takes captopril 25 mg twice a day. The nurse noted a duplication of therapy (two angiotensin-converting enzyme (ACE) inhibitors) and considered this discrepancy a potential clinically significant medication issue. Mr. B also stated that he took his last dose of paroxetine that morning. The nurse verified that the paroxetine bottle was empty. Mrs. B stated that she would not be able to obtain the medication until the next day. The nurse planned to instruct the physical therapist to verify that Mr. B obtained the medication during the physical therapy evaluation the next day. A review of laboratory values indicated a recent Hemoglobin A1C level of 8.5 percent.

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The nurse contacted the physician office during the SOC Assessment by telephone to discuss the outstanding patient care issues. The following clarifications to the orders were requested, and verbal confirmation was received during this telephone conversation:

- The captopril 25 mg and lisinopril 10 mg were discontinued.
- A new order for lisinopril/hydrochlorothiazide 20 mg–25 mg daily was prescribed, to be started the next day.
- Sliding scale insulin orders were confirmed, and it was noted that Mrs. B's assistance is required for blood glucose monitoring and insulin administration due to the patient's wrist strain.
- The following orders for wound care to the pressure ulcer on the sacrum were obtained: Cleanse the wound with normal saline and apply a hydrocolloid dressing, change dressing every third day and as needed if it becomes soiled. Use zinc and dry clean dressing daily until supplies arrive.

The nurse initiated the orders by reviewing them with Mr. B and wife, confirming their understanding, and ordering the wound care supplies. Per physician request, upon returning to the office, the nurse faxed him the medication list and the above recommendations. The following day, the physician signed and faxed the medication/recommendation list back to the nurse.

### **Excerpt From the HHA Physical Therapy Evaluation:**

On Day 2 of the episode, the physical therapist arrived to assess Mr. B. The patient reported that he took his paroxetine dose that morning and showed the physical therapist the refilled prescription bottle. Mr. B also verified that he took his first dose of lisinopril/hydrochlorothiazide. The physical therapist communicated this back to the nurse. The therapist noted that the patient uses a walker, and his gait was slow while walking 50 feet. He also required cueing to pick up his feet to clear the floor. Balance measurements were as follows: sit static normal, sit dynamic normal, and stand static fair. Transfer sit/stand technique and gait training were reviewed. A home exercise program was established to promote core strengthening activities and adaptive transfer technique. Mr. B complained of fatigue with shortness of breath. A ramp was recommended for the front steps into the house. However, his wife commented that they could not afford either rental or construction of a ramp, stating, "I don't know how I will get him to the doctor next week, because I don't drive and can't lift him down the steps." The physical therapist contacted the nurse case manager to case conference and discuss the need for further evaluation by the clinical social worker.

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### **Excerpt From the HHA Occupational Therapy Evaluation:**

The occupational therapist evaluated Mr. B 2 days after discharge from the hospital.

- Mr. B requires setup with minimal to moderate assistance for personal care activities.
- For showering, Mr. B requires intermittent assistance of one and a shower bench, which was already in the shower from his BKA.
- Mr. B can dress his upper body independently with setup but requires hands-on assistance for lower body dressing.
- Mr. B is independent in eating, after setup.

### **Excerpt From the Nursing Discharge Comprehensive Assessment:**

Mr. B was on service for 5 weeks and then refused further care. It was suspected that he had resumed his alcohol use, as his engagement in his home healthcare plan seemed to have declined. He had been lying in bed for extended periods of time and was not completing his exercises as instructed. His physician was made aware of these changes.

Two weeks ago, the patient developed a Stage 3 pressure ulcer on his right hip, measuring 2 cm × 3 cm × 0.5 cm. The current measurements of this wound are 2 cm × 2 cm × 0.5 cm, and the wound is pink with no slough. The original pressure ulcer on the sacrum was noted to be closed with intact skin. Skilled nursing services were reduced in frequency. Wound care for the new pressure ulcer on the hip was ordered by the physician to be done by Mrs. B. She was noted to be independent with the wound care treatment, as demonstrated by teach-back. Physical and occupational therapies were also reduced in frequency.

Mr. B's left wrist functionality had improved, although he still required the use of the walker. He was continent of bladder and bowel and independent in toileting. His gait had improved, demonstrating an ability to safely ambulate with a walker up to 75 feet. Mr. B was independent in blood glucose monitoring and managing his insulin administration. His blood glucose levels were elevated but still within the physician-ordered parameters for insulin coverage according to his sliding scale, with two exceptions. During the episode of care, he had two incidences of an elevated blood sugar > 350 but reported he was asymptomatic. The nurse considered this to be a potential clinically significant medication issue. On both occasions, the physician was notified and responded on the same day symptoms were noted by the home health agency, with no change in orders. No additional medication issues were identified during the episode of care.

Both Mr. B and his wife were instructed to follow up with his physician for the scheduled appointment in 1 week for a wound evaluation. The physician was notified by phone of the patient's request for discharge and confirmed the scheduled appointment for follow-up related to wound care in 1 week.