Recent Medical History

Mrs. S is a 70-year-old female admitted to an acute care hospital on November 3 following a fall. While walking down the hall to her bathroom, she lost her balance and fell when her dog got tangled in her walker. After her fall, she noted increasing right thigh and hip pain. She went to the emergency department, where she was diagnosed with a right proximal femoral fracture confirmed by X-ray. A skin assessment upon admission to the hospital revealed a large ecchymosis on her right thigh; skin was otherwise intact. Her past medical history includes hypertension, congestive heart failure, and depression. Mrs. S underwent surgery on November 4 for a total hip arthroplasty to repair her femoral fracture. Her postoperative status was stable; however, her progress with inpatient physical therapy was slow.

Mrs. S was referred to home care for nursing, occupational, and physical therapy services. She was discharged home on November 8. The discharge summary provided to the home health agency states that Mrs. S is unable to bear weight on her right lower extremity. Her discharge weight was 147 lbs., and her height was recorded as 5 feet, 2 inches.

Excerpt from the Home Health Start of Care (SOC) Assessment

Mrs. S lives with her son, Mark, in a two-level home. When the assessing clinician, a registered nurse (RN), arrives for the SOC assessment on November 9, Mrs. S and her son are in the kitchen having breakfast. The RN proceeds to interview Mrs. S and Mark and establishes that Mrs. S has not received home care services prior to this referral.

Mrs. S reports that prior to the fall that resulted in her hip fracture, she was independent with bathing, dressing, using the toilet, and eating. She walked by herself on indoor surfaces using a rollator walker. Mrs. S could go up and down the stairs to her bedroom on the second level using the handrail, with her son standing by just in case. Mrs. S used a manual wheelchair for longer distances due to endurance limitations. She reports being able to propel her wheelchair independently to her mailbox (approximately 70 feet). For distances greater than 70 feet, such as visits to her next-door neighbor, Mark would propel her. She also needed some help from Mark with medication management, paying her bills, and grocery shopping prior to her hip fracture.

Mrs. S reports that she follows a no-added-salt, regular consistency diet as identified on her discharge instructions. She reports that since her fall, Mark does the cooking and cleanup for her meals. He sets the table, prepares her plate, and fixes her tea for her.

Due to balance issues and safety concerns, Mark has set up a temporary bedroom for Mrs. S in the first-floor dining room. The RN observes Mrs. S as walks to the bedroom and sits on the side of the bed where Mark brings her a tray containing a toothbrush, toothpaste, water, and a basin. Mrs. S proceeds to brush her teeth without assistance. Once she is done, Mark removes the tray and hygiene items.

Mrs. S then asks the nurse for assistance with voiding. There is a bedside commode located in the bedroom that she indicates she wants to use. The RN assists her to the commode and steadies Mrs. S as she lowers her slacks and underwear. The RN holds the weight of her trunk as she slowly lowers Mrs. S onto the bedside commode. After she finishes voiding, the RN holds her trunk as Mrs. S wipes herself and moves to a standing position. Once she has gained her balance, Mrs. S adjusts her underwear and slacks, with the RN standing by to ensure her safety. Mrs. S then returns to bed.

The RN conducts a skin assessment and observes that the right femoral surgical incision is clean, dry, and well-approximated with surgical staples closing the 10-cm incision line. Her skin is otherwise intact. Mrs. S' right lower extremity has intact peripheral pulses, normal sensation to light touch, and normal movement of the toes. Due to balance issues, Mrs. S was unable to stand on the scale to obtain an accurate weight. Her height was measured in bed as 5 feet, 2 inches.

In reviewing the discharge instructions, the RN notes that Mrs. S must sponge bathe until her staples are removed. Mrs. S reports that Mark assisted her with a sponge bath yesterday, after she returned home. Mrs. S described her limited ability in washing her chest, arms, and anterior thighs, but indicated she became weak and required Mark to wash her perineal area, legs, feet, and back. Mark also needed to dry her due to fatigue.

To help Mrs. S get dressed for the day, Mark brings her blouse, pants, undergarments, socks, and shoes. Mrs. S puts on and fastens her bra, threads her arms through the sleeves of her blouse, and fastens the buttons without needing any assistance. Mrs. S needs help putting on her underwear, pants, socks, and shoes. While sitting on the side of the bed, Mark puts her legs into the underwear and pants and pulls them up to her mid-thigh. Mrs. S stands and, with trunk support from Mark to stabilize her balance, she pulls the garments up to her waist. Mrs. S is unable to reach her feet to put on her socks. Mark places the shoes in front of her, puts on her socks, and Mrs. S slides her feet into her slip-on shoes.

After this assessment, the RN asks Mrs. S about her future goals and thoughts about returning to her prior level of function regarding self-care. That discussion resulted in the following discharge goals:

- Mrs. S and the nurse anticipate that she will be able to set up the table, prepare her own meals, and perform her oral hygiene independently.
- Mrs. S and the nurse anticipate that she will be able to get on and off the bathroom toilet, using a raised toilet seat, and manage her perineal hygiene and clothing without any assistance.
- Mrs. S and the nurse anticipate that she will be able to bathe and dry herself completely with standby assistance from Mark.
- Mrs. S and the nurse expect that she will be independent with dressing her upper and lower body and putting on/taking off footwear.

The RN then completed a drug regimen review, noting the patient has no known drug allergies. Later that day, the nurse faxed the patient's SOC medication list to the physician as follows:

- Lisinopril 10 mg by mouth daily.
- Ibuprofen 400 mg by mouth every 4 hours as needed for mild pain.
- Venlafaxine 75 mg by mouth daily.
- Furosemide 20 mg by mouth twice a day.
- Potassium chloride 20 mEq by mouth once daily.
- Enoxaparin 40 mg subcutaneous daily for 20 days post-operatively (last dose to be administered on November 24).

Interdisciplinary Conference Note

The physical therapist (PT) conducted an evaluation on November 10, the day following the SOC assessment. The RN schedules an interdisciplinary conference the next day to review her SOC assessment data. The RN validates her findings, as noted below, from the SOC assessment with the PT:

- **Roll left and right**: Mrs. S required the nurse to position a pillow between her legs to prevent adduction of the affected extremity and then to assist her to roll from side to side in bed. The nurse provided most of the effort. It is anticipated that Mrs. S will be independent with this activity by discharge.
- **Sit to lying:** Once in a seated position, Mrs. S required the assistance of the nurse to bring both legs back into bed, as well as to support her trunk. Due to fatigue, Mrs. S was only able to use her right arm to lower herself to a supine position, contributing minimal effort. It is anticipated that Mrs. S will be independent with this activity by discharge.
- **Lying to sitting on side of bed**: Mrs. S could bring her left leg off the bed and assist with pushing up with her right arm. She required maximum assistance to bring her right leg off the side of the bed and needed to be supported by the nurse to come to a sitting position. It is anticipated that Mrs. S will require standby assistance with this activity by discharge.
- **Sit to stand**: Mark assisted Mrs. S by supporting her trunk and bearing most of her weight as Mrs. S moved to a standing position. He stood by Mrs. S while she steadied herself with her rollator walker. It is anticipated that Mrs. S will be independent with this activity by discharge.
- **Chair/bed-to-chair transfer**: The PT reported the use of a gait belt to support Mrs. S' trunk as she pivot transferred from sitting on the side of the bed into a wheelchair. In addition, Mrs. S required the therapist to position the rollator walker prior to and during the transfer and provide verbal cues. The nurse observed a similar level of function at SOC. The nurse and therapist agree that this would be considered the patient's usual ability. It is anticipated that Mrs. S will require standby assistance with this activity by discharge.

- **Car transfer**: Mark reported that they only have one family vehicle, which is currently in the shop for repairs. As a result, it was not possible to assess a car transfer during the SOC assessment timeframe. It is anticipated that by discharge, Mrs. S will be able to complete car transfers with contact guard assistance and the use of a rollator walker.
- **Walk 10 feet**: Mrs. S walked 10 feet with a rollator walker and assistance from Mark. She required steadying assistance as she began to walk. Mrs. S become fatigued and required Mark to provide partial assistance by holding her belt to complete the last 3 feet of the 10-foot walk. By discharge, it is expected that Mrs. S will be independently walking 10 feet using a rollator walker.
- **Walk 50 feet with two turns:** This activity was not attempted due to the patient's fatigue and decreased endurance. Currently, Mrs. S requires a manual wheelchair for distances beyond 15 feet. Based on her prior mobility status and motivation to improve, it is anticipated that Mrs. S will require contact guard assistance when walking 50 feet and making two turns using a rollator walker by discharge.
- **Walk 150 feet:** This activity was not attempted as Mrs. S was not walking more than 60 feet prior to her hip fracture. A discharge goal for walking 150 feet is not applicable.
- **Walking 10 feet on uneven surfaces**: This activity was not attempted due to the patient's fatigue and decreased endurance. Prior to her hip fracture, Mrs. S reported being able to walk 10 feet on uneven surfaces with standby assistance using her rollator walker. By discharge, it is expected that Mrs. S will return to this prior level of function.
- **1 step (curb), 4 steps, 12 steps**: These activities were not attempted at SOC due to the patient's medical condition and safety concerns. However, based on the RN's clinical judgement and Mrs. S' motivation to improve, it is anticipated that Mrs. S will be able to complete these activities with her son standing by her in case assistance is needed by discharge.
- **Picking up object**: This activity was not attempted due to Mrs. S' medical condition and safety concerns. Mrs. S. reported that she never had trouble picking up an object from the floor prior to her hip fracture. By discharge, it is expected that Mrs. S will be able to complete this activity from a bending or stooping position after setup of adaptive equipment, such as a reacher.
- **Wheel 50 feet with two turns**: Once seated in her manual wheelchair, Mrs. S propels herself 20 feet and completes two turns with some assistance from Mark to straighten herself after a turn. Mark propels her wheelchair for the last 30 feet due to her poor endurance. It is anticipated that by discharge her endurance will improve and Mrs. S will complete this activity without any assistance.
- **Wheel 150 feet**: After propelling herself 20 feet, Mrs. S becomes fatigued and Mark must complete the remaining 130 feet distance. By discharge, it is anticipated that Mrs. S will return to her prior level of function, self-propelling her manual wheelchair approximately 70 feet, and will require help to complete further distances, such as 150 feet.

Excerpt from the Home Health Episode of Care

During a routine home health visit on November 26, Mrs. S reported that she fell 3 days ago while attempting to go upstairs without assistance to retrieve her knitting supplies. Upon assessment, the RN noted a bruise and a healing abrasion on her right shoulder. The RN validated that Mrs. S could move all extremities without pain and had no other complaints of injury related to this fall.

Excerpt from the Home Health Discharge Assessment

Mrs. S has had steady improvement in her functional mobility and self-care status. The RN schedules an interdisciplinary conference on December 7 and validates her assessment findings with the occupational therapist (OT) and PT, as noted below:

- **Eating:** Mrs. S can set the table and prepare her own meals. She can eat and drink without assistance.
- **Oral hygiene:** Mrs. S can brush her teeth without assistance.
- **Toilet transfer and Toileting hygiene:** Mrs. S can get on and off the bathroom toilet using a raised toilet seat without any help. She can manage her toileting hygiene without any assistance.
- **Shower/bathe Self:** Mrs. S can wash her body independently in the shower while seated on a shower chair for safety.
- **Upper body dressing:** Mrs. S completes upper body dressing independently.
- **Lower body dressing:** Mrs. S completes lower body dressing using adaptive equipment without any assistance.
- **Putting on/taking off footwear:** Mrs. S puts on and takes off her socks and shoes using adaptive equipment without needing any help.
- **Roll left and right:** Mrs. S rolls side to side and onto her back without any assistance.
- **Sit to lying:** Mrs. S moves from a sitting to supine position without any assistance.
- **Lying to sitting on side of bed:** Mrs. S moves from a supine to a sitting position without any assistance.
- **Sit to stand:** Mrs. S can stand from a sitting position without any assistance. Once standing, she uses her rollator walker to steady herself.
- **Chair/bed-to-chair transfer:** Mrs. S completes chair/bed-to-chair transfer using her rollator walker without any assistance.
- **Car transfer:** Mrs. S can complete a car transfer with contact guard assistance using her rollator walker.
- **Walk 10 feet:** Mrs. S walks 10 feet using a rollator walker without assistance.

- **Walk 50 feet with two turns:** Mrs. S walks 50 feet, making two turns using a rollator walker and contact guard assistance from her son due to her balance limitations.
- **Walk 150 feet:** Mrs. S cannot walk the entire distance required for this activity. This activity was not attempted, as Mrs. S was not walking 150 feet prior to her current injury.
- **Walking 10 feet on uneven surfaces:** Mrs. S walks 10 feet on uneven surfaces with contact guard assistance using her rollator walker.
- **1 step (curb), 4 steps, 12 steps:** Mrs. S could go up and down 1 step, 4 steps, and 1 flight of stairs (12 steps) with the contact guard assistance from her son.
- **Picking up object:** Mrs. S retrieves an object by bending from a standing position independently after setup of adaptive equipment.
- **Wheel 50 feet with two turns:** Mrs. S wheels herself 50 feet using her manual wheelchair and completes two turns without any assistance.
- **Wheel 150 feet:** Mrs. S wheels herself 60 feet, which is nearly as far as her prior level of function. A helper is needed to propel her manual wheelchair 90 feet, the remaining distance of the 150 feet.

The OT and PT agreed with the RN's assessment. Mrs. S was discharged from occupational and physical therapy services on December 8. Mrs. S has not had any clinically significant medication issues and has not reported any additional falls. She remains on a no-added-salt diet, demonstrating excellent adherence to this dietary restriction. The surgical site is now fully healed with minimal scarring. Mrs. S was discharged from home health services on December 10.