Recent Medical History

Mrs. S is a 78-year-old female who was admitted to an acute care hospital on November 3 with respiratory distress and right hip pain following a fall. For 2 weeks prior to admission, she noted progressive difficulty breathing and weakness, resulting in a fall at home. She spent several hours on the floor before assistance arrived. Upon admission to the hospital, she was noted to have respiratory failure, a right proximal femoral fracture, and a deep tissue injury (DTI) on the right lateral malleolus. Her past medical history includes hypertension, congestive heart failure, chronic obstructive pulmonary disease, and depression.

While in the hospital, Mrs. S underwent total hip arthroplasty surgery to repair her femoral fracture. Due to her extended need for ventilation, she had a tracheostomy placed. Mrs. S also has a peripherally inserted central catheter (PICC) for intravenous (IV) access and a gastrostomy tube (G-tube) for nutritional support.

During her acute care hospitalization, Mrs. S developed a Stage 4 pressure ulcer on her coccyx, measuring 4 cm by 3 cm by 2.5 cm.

After 3 weeks of acute care hospitalization, her clinical status improved and she was weaned off the ventilator. Her tracheostomy was capped and she was placed on oxygen at 2 liters per minute via nasal cannula. She was able to maintain her oxygen saturation at 92–94 percent. During the following week, Mrs. S was able to maintain adequate oxygen saturation on room air, and her supplemental oxygen was discontinued.

Given her medical conditions and continued need for respiratory and physical rehabilitation, she was transferred to a post-acute care (PAC) setting on December 1. Upon discharge from the acute care hospital, Mrs. S continued to have a capped tracheostomy and a PICC line. Mrs. S was weight bearing as tolerated on her right lower extremity. The indwelling catheter was removed 24 hours prior to discharge, and the patient was voiding without difficulty.

Prior Level of Function

Mrs. S lives with her son in a two-level home. Prior to the recent hospitalization, Mrs. S was independent with self-care activities, and required assistance with some mobility activities and instrumental activities of daily living (IADL). She walked on indoor surfaces with a rollator walker, but required her son to provide standby assistance when climbing stairs. For longer distances of 60 feet or greater, Mrs. S required a manual wheelchair due to endurance limitations. She reports being able to propel the wheelchair independently for short distances, like going to her mailbox (approximately 70 feet). For distances greater than 70 feet, such as visits to her next-door neighbor, a helper propelled her in her wheelchair. She also needed some assistance with medication management prior to admission.

Excerpt From the Nursing Admission Note

Upon admission to the PAC setting**,** the PICC line insertion site is clean, dry, and the PICC line patent. The G-tube is intact and patent. Mrs. S has orders to have nothing by mouth (NPO). She is receiving tube feedings secondary to a swallowing disorder per failed video fluoroscopic swallowing study. It is anticipated that Mrs. S will have her G-tube removed and resume oral feeding. Her tracheostomy is capped and intact with minimal secretions. Mrs. S is maintaining oxygen saturation at 92 percent on room air. The right lower extremity has intact peripheral pulses, normal sensation to light touch, and movement of the toes.

The nurse conducts a skin assessment and notes the following findings:

- Coccyx pressure ulcer presents with full thickness tissue loss. It is clean with granulation tissue evident in the wound bed. The ulcer measures 3.5 cm by 3 cm by 1.5 cm.
- Right lateral malleolus has an intact blood-filled blister and is soft and boggy upon palpation. It is determined to be a DTI.
- Right femoral surgical site is clean, dry and well-approximated with surgical staples closing the 10-cm incision line.

The nurse reviews the acute care transfer notes and identifies the previous stage of the coccyx pressure ulcer as a Stage 4. She also notes documentation regarding a DTI on the right lateral malleolus.

Excerpt From the Pharmacy Admission Note

On the day of transfer to the PAC setting, the pharmacist reviews the patient's admission medication orders, as follows:

- Lisinopril 10 mg (1 mg/ml) via G-tube daily
- Docusate 100 mg (50 mg/5 ml) via G-tube twice a day
- Ibuprofen 600 mg (100 mg/5 ml) via G-tube every 4 hours as needed for mild to moderate pain
- Ibuprofen 400 mg via G-tube every 4 hours for mild pain or fever
- Venlafaxine 75 mg (15 mg/ml) via G-tube daily
- Furosemide 40 mg IV twice a day
- Potassium chloride elixir 20 mEq (20 mEq/15 ml) via G-tube twice a day
- Famotidine 20 mg (40 mg/5 ml) via G-tube twice a day
- Fluticasone propionate HFA 110 mcg – inhale 1 puff twice a day
- Prednisolone 60 mg (15 mg/5 ml) via G-tube daily

The pharmacist notes that the patient has no known drug allergies. However, two different doses of the same medication to address mild pain were ordered, which could exceed the maximum daily dosage for ibuprofen. The pharmacist identifies this as duplicate therapy and determines it is a clinically significant medication issue. He contacts the admitting physician and leaves a message to discuss these orders. One hour later, the admitting physician returns the pharmacist's phone call to clarify and change the order, as follows:

- **Original orders discontinued:**
  - Ibuprofen 600 mg (100 mg/5 ml) via G-tube every 4 hours as needed for mild to moderate pain
  - Ibuprofen 400 mg via G-tube every 4 hours for mild pain or fever
- **Revised order:**
  - Ibuprofen 400 mg (100 mg/5 ml) via G-tube every 4 hours as needed for mild to moderate pain or fever

That evening, the charge nurse notes and implements the order.

Excerpt from Occupational Therapy Admission Evaluation

Upon initial evaluation, Mrs. S was found to have the following levels of function.

- **Eating:** Mrs. S is currently receiving nutrition solely via G-tube due to NPO order. It is anticipated that oral nutrition will be reintroduced during her PAC stay with the discharge goal of Mrs. S eating and drinking, without any type of assistance.
- **Oral hygiene:** Mrs. S brushes her teeth once a helper sets up and then cleans up her oral hygiene items placed on her bedside table. It is anticipated Mrs. S will not require any type of assistance with this activity by discharge.
- **Toilet transfer and toileting hygiene:** Mrs. S requires the assistance of one helper. The helper provides some assistance to slowly lower her, with trunk support (less than half of the effort) onto the bedside commode, and provides contact guard assistance as Mrs. S gets off the bedside commode. Once she is standing before the bedside commode, she requires steadying assistance from one helper while Mrs. S adjusts her underwear and slacks. After she finishes voiding, Mrs. S wipes herself and adjusts her underwear with contact guard assistance from a helper. It is expected that Mrs. S will perform toilet transfers and manage her perineal hygiene, underwear, and slacks without any type of assistance by discharge.

Excerpt from Physical Therapy Admission Evaluation

Upon initial evaluation, Mrs. S was found to have the following levels of function related to mobility:

- **Walk 10 feet:** Mrs. S walks 10 feet with a rollator walker and assistance of one helper. She requires steadying as she begins to walk and then progressively requires some of her weight to be supported for the last 3 feet of the 10-foot walk. By discharge, it is expected that Mrs. S will require standby assistance from one helper while walking 10 feet using a rollator walker.
- **Walk 50 feet with two turns:** This activity was not attempted due to her fatigue and decreased endurance. Currently, Mrs. S requires a manual wheelchair for distances beyond 15 feet. Based on her prior mobility status, comorbidities, current functional performance, and motivation to improve, it is anticipated that Mrs. S will require contact guard assistance when walking 50 feet and making two turns by discharge using a rollator walker.
- **Walk 150 feet:** This activity was not attempted as Mrs. S was not walking more than 60 feet prior to her current injury. The discharge goal is not applicable for walk 150 feet.
- **Wheel 50 feet with two turns:** Once seated in her manual wheelchair, Mrs. S propels herself about 20 feet and completes two turns with some assistance to straighten herself after a turn. The helper propels her wheelchair for the last 30 feet due to her poor endurance. It is anticipated that by discharge Mrs. S will increase her endurance and complete this activity without any type of assistance.
- **Wheel 150 feet:** After propelling herself 20 feet, Mrs. S becomes fatigued and the therapist must complete the remaining 130 feet distance. By discharge, it is anticipated that Mrs. S will return to her prior level of ability, independently self-propelling her wheelchair approximately 70 feet, and then require a helper to complete further distances, such as 150 feet.

Excerpt From the Interdisciplinary and Physician Progress Notes

Mrs. S continues to demonstrate a stable respiratory status on room air with her tracheostomy capped, maintaining an oxygen saturation level of 90–92 percent. On day 8, Mrs. S is decannulated. She continues to demonstrate respiratory stability and adequate oxygen saturation after the tracheostomy is removed. She has progressed to taking food and liquids safely by mouth. Her PICC line is discontinued and the route of the furosemide order is changed to oral. Mrs. S continues on supplemental G-tube feedings to support her caloric intake.

On day 10, Mrs. S has a sudden onset of severe pain in her right ankle after bumping it against the bed rail. She reports her pain as severe, rating it a 10 out of 10 on the pain scale. The nurse assesses Mrs. S' right ankle and finds that the DTI has opened, draining copious amounts of serosanguinous fluid and bone is visible. The physician is contacted and arrives to evaluate Mrs. S. An order is obtained for a wound care consult and hydrocodone 10 mg by mouth every 4 hours as needed for severe pain. At 11 a.m. that day, the nurse administers her first dose of hydrocodone. The nurse returns in 30 minutes to evaluate the effect of the medication and notes that Mrs. S is lethargic and exhibiting mental status changes. Mrs. S begins to experience shortness of breath. The physician is called and immediately arrives on the unit to evaluate Mrs. S. He administers naloxone to reverse the effects of the medication. He also orders 4 liters of oxygen via nasal cannula and discontinues the order for hydrocodone. Within the next 24 hours, Mrs. S stabilizes and the wound care consult is completed, revealing a Stage 4 pressure ulcer. During the next week, she is successfully weaned to room air, maintaining oxygen saturations of 90–92 percent.

On day 14, the pressure ulcer on the coccyx has begun to show improvement. It now measures 3 cm by 2 cm by 1 cm, and it is clean with granulation tissue. The pressure ulcer on the right ankle has full thickness tissue loss, exposing bone, and continues to drain copious amounts of fluid. Evidence of maceration is noted on the wound edges.

Excerpt from Occupational Therapy Discharge Assessment Note

Upon evaluation at discharge, Mrs. S was found to have the following levels of function.

- **Eating:** Mrs. S receives nutrition and hydration orally. She opens containers and uses utensils to self-feed, and a cup/glass to drink liquids without assistance. Mrs. S receives additional nutrition between meals via G-tube as her oral intake requires supplementation.
- **Oral hygiene:** Mrs. S performs all oral hygiene tasks without any type of assistance.
- **Toilet transfer and toileting hygiene:** Mrs. S performs toilet transfers and toileting hygiene without any type of assistance from a helper.

Excerpt from Physical Therapy Discharge Assessment Note

Upon evaluation at discharge, Mrs. S was found to have the following levels of function related to mobility:

- **Walk 10 feet:** Mrs. S walks 10 feet using a rollator walker with supervision from a helper due to her balance limitations.

- **Walk 50 feet with two turns:** Mrs. S walks 50 feet, making two turns using a rollator walker and contact guard assistance from a helper 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.
- **Wheel 50 feet with two turns:** Mrs. S wheels herself approximately 60 feet and completes two turns without any type of 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 wheelchair the remaining distance of the 150 feet.

Excerpt From the Nursing Discharge Note

Mrs. S continues to improve and her respiratory status remains stable. She has not had any additional clinically significant medication issues. Mrs. S has resumed oral feedings, but will continue to receive supplemental G-tube feeding post-discharge until her nutritional status improves.

The pressure ulcer on her coccyx has closed with epithelial tissue. The pressure ulcer on the right malleolus has deteriorated. It is 100-percent covered by slough, and the wound bed cannot be visualized.

On day 22, Mrs. S is discharged to home with a referral to a home health agency for nursing and therapy, mobility, nutrition, and ongoing wound care.