

Recent Medical History

Mr. K is a 76-year-old male who was admitted to an acute care hospital on March 10 with congestive heart failure (CHF) and right hip pain. For 2 weeks prior to admission, he noted progressive difficulty breathing and weakness, resulting in a fall at home. Mr. K spent several hours on the floor before assistance arrived. Upon admission to the acute care hospital, he was diagnosed with a right proximal femoral fracture, exacerbation of CHF, and a deep tissue injury (DTI) on the right lateral malleolus. His past medical history includes hypertension, CHF, and depression.

While in the acute care hospital, Mr. K underwent total hip arthroplasty surgery on March 11 to repair his femoral fracture. He required diuresis to manage the CHF and had an indwelling urinary catheter inserted. He also required supplemental oxygen for a short time postoperatively due to CHF and was subsequently weaned to a nasal cannula at 2 liters per minute. While hospitalized, Mr. K developed a Stage 4 pressure ulcer on his coccyx, measuring 3.5 cm by 3.0 cm by 1.5 cm.

His postoperative status was stable; however, progress with inpatient physical therapy was slow. Given his medical condition and ongoing need for respiratory and physical rehabilitation, Mr. K was transferred to the inpatient rehabilitation facility (IRF) on March 20. Upon discharge from the acute care hospital, Mr. K remained on nasal oxygen at 2 liters per minute. The indwelling catheter was removed 24 hours prior to discharge, and the patient was voiding without difficulty.

Prior Level of Function

Mr. K lives with his daughter, Ruth, in a two-level home. Prior to his recent hospitalization, he was independent with bathing, dressing, using the toilet, and eating. He walked up to 60 feet by himself from room to room using a rollator walker. Mr. K could go up and down the stairs to his bedroom on the second level using the handrail, with his daughter standing by just in case. Mr. K used a manual wheelchair for longer distances due to endurance limitations. He reports being able to propel his wheelchair independently to his mailbox (approximately 70 feet). However, when attempting to wheel greater distances, Mr. K requires assistance from Ruth due to fatigue. He was independent with all tasks involving his memory and problem-solving skills, and was able to manage his own medications, pay his bills, and grocery shop prior to being admitted to the acute care hospital.

Excerpt From the Nursing Admission Note

Upon admission to the IRF, Mr. K is alert and oriented. His right lower extremity has intact peripheral pulses, normal sensation to light touch, and movement of the toes. He is receiving nasal oxygen at 2 liters per minute, and his lungs are clear to auscultation bilaterally.

The registered nurse (RN) conducts a skin assessment and notes the following findings:

- Coccyx pressure ulcer presents with partial thickness tissue loss. It is clean with epithelial tissue at the wound edges and granulation tissue filling the wound bed. The ulcer measures 2.0 cm by 1.0 cm by 0.25 cm.
- Right lateral malleolus has an intact blood-filled blister and surrounding tissue 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 RN reviews the acute care transfer notes and identifies documentation that the coccyx pressure ulcer was classified as a Stage 4. The RN also notes documentation regarding a DTI on the right lateral malleolus.

Excerpt From the Pharmacy Admission Note

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

- Lisinopril 10 mg by mouth daily.
- Docusate 50 mg by mouth daily.
- Ibuprofen 600 mg by mouth every 4 hours as needed for mild to moderate pain.
- Venlafaxine 75 mg by mouth daily.
- Furosemide 20 mg by mouth twice a day.
- Potassium chloride 20 mEq by mouth once daily.
- Ibuprofen 400 mg by mouth every 4 hours as needed for mild pain or fever.
- Enoxaparin 40 mg subcutaneous daily for 20 days post-operatively (last dose to be administered on March 31).

The pharmacist notes that the patient has no known drug allergies. However, he identifies that 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. 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 by mouth every 4 hours as needed for mild to moderate pain.
 - Ibuprofen 400 mg by mouth every 4 hours as needed for mild pain or fever.

- **Revised order:**
 - Ibuprofen 400 mg by mouth 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

Mr. K follows a no-added-salt, regular consistency diet. Once a meal tray is placed in front of Mr. K, he requires a certified nursing assistant (CNA) to cut his food into small pieces and open containers. Mr. K is then able to eat without assistance. It is anticipated that Mr. K will return to his prior level of eating independently at discharge.

Mr. K requires a CNA to set up his oral hygiene items in the bathroom. For safety, the CNA supervises as Mr. K brushes his teeth while standing. Once he completes this activity, the CNA puts the items away and provides contact guard as he walks back to bed. It is anticipated Mr. K will not require any type of assistance with this activity by discharge.

Mr. K uses a raised toilet seat and requires the assistance of a helper to complete toilet transfers and toileting hygiene. The helper provides contact guard as Mr. K lowers his slacks and underwear. The helper then supports Mr. K's trunk while slowly lowering him onto the toilet, with the patient providing most of the effort. After he finishes, Mr. K wipes himself and the helper provides some lifting assistance (with Mr. K providing most of the effort) as Mr. K gets off the toilet. Once he is standing, Mr. K requires steadying assistance from the helper while he adjusts his underwear and slacks. The occupational therapist anticipates that Mr. K will perform toilet transfers and manage his perineal hygiene, underwear, and slacks without any type of assistance by discharge.

Excerpt from Physical Therapy Admission Evaluation

Mr. K walks 10 feet with a rollator walker and assistance of one helper. He requires steadying as he begins to walk and then progressively requires some of his weight to be supported for the last 3 feet of the 10-foot walk. By discharge, it is expected that Mr. K will require standby assistance from one helper while walking 10 feet using a rollator walker.

Due to the patient's fatigue and decreased endurance, the physical therapist (PT) was unable to evaluate Mr. K's ability to walk 50 feet with two turns. Currently, Mr. K requires a manual wheelchair for distances beyond 15 feet. Based on his prior mobility status, comorbidities, current functional performance, and motivation to improve, the PT anticipates that Mr. K will require contact guard assistance when walking 50 feet and making two turns using a rollator walker by discharge.

The PT did not attempt to evaluate Mr. K's ability to walk 150 feet, as Mr. K was not walking more than 60 feet prior to his current injury. The discharge goal is not applicable for walk 150 feet.

Once seated in his manual wheelchair, Mr. K propels himself about 20 feet and completes two turns with some assistance from a helper to straighten himself after a turn. The helper propels his wheelchair for the last 30 feet due to his poor endurance. It is anticipated that by discharge Mr. K will increase his endurance and complete this activity without any type of assistance.

When assessing his ability to wheel longer distances in the manual wheelchair, the PT identifies that Mr. K usually becomes fatigued after propelling 20 feet and the therapist must complete the remaining 130 feet distance. By discharge, it is anticipated that Mr. K will be able to self-propel his wheelchair approximately 70 feet (his prior level), and then will require a helper to assist with completing further distances, such as 150 feet.

Excerpt From the Interdisciplinary and Physician Progress Notes

Mr. K continues to demonstrate a stable respiratory status and is successfully weaned to room air maintaining an oxygen saturation level of 90–92 percent.

On day 5 of the IRF stay, Mr. K complains of a sudden onset of severe pain in his right ankle after bumping it against the foot rest of the wheelchair. He reports his pain as severe, rating it a 10 out of 10 on the pain scale. The RN assesses Mr. K'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 the patient. He orders a wound care consult and hydrocodone bitartrate and acetaminophen 5mg/500mg – one tablet every 6 hours as needed for ankle pain.

At 11 a.m. that day, the RN administers the first dose of the newly prescribed pain medication. The nurse returns in 30 minutes to evaluate the effect of the medication and notes that Mr. K is experiencing nausea, dizziness, and itching of the face and throat. The physician is called and immediately arrives on the unit to evaluate Mr. K. The physician orders a dose of intravenous diphenhydramine, which was given immediately by the nurse. He also orders 2 liters of oxygen via nasal cannula and discontinues the order for the hydrocodone bitartrate and acetaminophen. The physician orders diphenhydramine 25 mg by mouth every 6 hours as needed for the allergic symptoms. He discontinues the existing order for ibuprofen and increases the dose to ibuprofen 800 mg by mouth every 6 hours as needed for ankle pain and reinforces the need to monitor for bleeding.

Within the next 24 hours, Mr. K stabilizes, and the wound care consult is completed. The right ankle is numerically staged as a Stage 4 pressure ulcer. Wound care treatments are initiated, and the patient's pain is effectively managed on ibuprofen, with no signs or symptoms of bleeding.

During the next week, he is successfully weaned to room air, maintaining oxygen saturations of 90–92 percent.

On day 8, the pressure ulcer on the coccyx has begun to show improvement. It now measures 1.5 cm by 1.0 cm by 0.5 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. The choice of dressing is reevaluated to protect the surrounding skin while managing drainage.

Excerpt from Occupational Therapy Discharge Assessment Note

Mr. K continues to tolerate a no-added-salt, regular consistency diet. He opens containers and uses utensils to feed himself and a cup/glass to drink liquids without assistance. Mr. K brushes his teeth and performs all oral hygiene tasks without any type of assistance. Mr. K performs toilet transfers using a raised toilet seat and manages his perineal hygiene, underwear, and slacks without any type of assistance from a helper.

Excerpt from Physical Therapy Discharge Assessment Note

Mr. K walks 10 feet using a rollator walker with supervision from a helper due to his balance limitations. He walks 50 feet, making two turns using a rollator walker and contact guard assistance from a helper. Mr. K cannot walk the entire distance required for the activity of walking 150 feet. This activity was not attempted as Mr. K was not walking 150 feet prior to his current injury.

Mr. K wheels himself approximately 60 feet and completes two turns using a manual wheelchair without any type of assistance. He is unable to wheel 150 feet. Mr. K wheels himself 60 feet, which is close to his prior level of function. A helper is needed to propel his manual wheelchair 90 feet, the remaining distance of the 150 feet.

Excerpt From the Nursing Discharge Note

Mr. K continues to improve. His cardiopulmonary status has stabilized, surgical staples have been removed and the surgical incision has fully healed. Effective pain control has been achieved and he no longer requires analgesics. Mr. K has not had any additional clinically significant medication issues.

The pressure ulcer on his 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 14, Mr. K is discharged to home with a referral to a home health agency for nursing and therapy services to address his ongoing needs related to mobility and wound care.