RT5-Long term care H&P2

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**Identification:**

Patient’s name: Mrs. W

DOB: 79 years old

Gender: female

Race: Caucasian

Location: Margaret Tietz, Jamaica, NY

Date and Time: 6/17/2019, 11am

Informant: patient, patient’s daughter, home aide, and transfer records

**CC:** “I feel like I cannot breathe” X 1 week

**HPI:** A 79 y/o female w/ PMHx of HTN, CHF, anemia, constipation, right hip fracture s/p ORIF was admitted to Margaret Tietz on 6/17/19 from NYPQ where patient was admitted on 6/13/19 for SOB and respiratory distress. Patient was retired and lives alone in a private house with 4 steps in total; as per patient’s daughter, patient has 24-hour/7days aide and ambulates with a walker at home; and patient’s BP is controlled with Lisinopril, taking Lasix (20mg QD), and monitor weight weekly for heart failure, iron supplement for anemia, and Colace and glycolax for constipation and home aide will help with medication preparation, for example, glycolax mix with water. Patient states that she has been feeling unwell for 1 week with progressively shortness of breath. Home aide reports noticing weight gain of 6.5 lbs, decreased urinary output and worsening swelling at lower extremities for the past week. Patient also reports nonproductive coughing, moaning, and more dyspneic upon exertion for 2 days, and she was brought to NYPQ by her daughter since these symptoms are not improving. Patient denies chest pain, palpitation, fever, chills, abdominal pain or dysuria. Patient was admitted to NYPQ and diagnosed with decompensated CHF. She was given normal saline 500ml, and Lasix 40mg IV push twice in the ER. After admission, continuous on Lasix 40mg IV BID, add Spironolactone 25mg QD, 2L oxygen therapy via nasal canula, and pneumococcal 23-valent vaccine once subQ.

Hospital diagnostic studies:

CXR on 6/13/19: Low lung volumes are seen. A left retrocardiac opacity is questioned, possibly PNA or pleural effusion. Repeated on 6/16/19: left pleural effusion.

US Venous Doppler Bilateral: No DVT seen in the visualized veins: in the common femoral veins or popliteal veins bilaterally, in the left superficial femoral vein, or in the visualized portions of the right superficial femoral vein. Lack of visualization and direct evaluation of the portion of the right common femoral vein in the distal right thigh.

Pt deemed stable and transferred to Margaret Tietz for skilled rehab services, including ADLs help and oxygen therapy. Pt seen and exanimated at bedside; patient presents most part of history, and her daughter and home aide also report part of history. Patient reports worsen constipation since hospitalization and random nonproductive cough, and denies fever, chills, chest pain, SOB, wheezing, palpitation, dysuria or frequency change. No other acute medical complaints at this time.

**Advance Directive**: full code

**PMH:**

HTN

CHF

Anemia

Constipation

Right hip fracture s/p ORIF

**Past Surgical History:**

ORIF for right hip fracture-2013

**Current Medications:**

Lisinopril 10mg PO QD for HTN

Lasix 40mg PO BID for CHF

Spironolactone 25mg QD for CHF

Colace 200mg PO QHS for constipation

Glycolax 17g mix with 8oz water PQ QHS for constipation

Ferrous 325mg PO QD for anemia

Vitamin C 500 mg PO QD for supplementation

Multivitamin 1 tab PO QD for 3 months for vitamin supplementation

**Allergies:**

Patient denies any drug, foods, or environment allergies.

**Family History:**

Father- 80s, deceased, natural cause

Mother-80s, deceased, natural cause

Daughter- 54, alive, anemia

**Social History:**

After spouse passed away, Mrs. W lives alone in private house with 4 steps in Queens with 24hours/7days home aide. She used to be a kindergarten teacher. Usually sleeps well with average of 6-7 hours sleep. Walked with walker about 20 min every day in the neighborhood. Sexually inactive. Denies recent travel, nicotine use, alcohol consumptions, past or present illicit drug use.

**ROS:**

General: *reports weight gain of 6.5 lbs in one week*, and denies loss of appetite, recent weight loss, fever, chill or night sweats

Skin, Hair, Nails: denies any changes of texture, discolorations, pigmentations, moles, rashes

Head: denies headache, vertigo, head trauma, or fracture

Eyes: denies visual disturbance, lacrimation, photophobia

Ears: denies deafness, pain, discharge, tinnitus

Nose/Sinuses: denies discharge, epistaxis, or obstruction

Mouth and throat: denies bleeding gums or sore throat

Neck: Patient denies localized swelling or lumps, stiffness

Pulmonary System: *reports cough* and denies hemoptysis, cyanosis, SOB

Cardiovascular System: denies chest pain, palpitations, edema, syncope

Gastrointestinal System: *reports constipation (usually controlled with medications, but less bowel movement since hospitalization)*, and denies nausea, vomiting, abdominal pain, diarrhea, dysphagia, rectal bleeding

Genitourinary System: *reports decreased urine output*, and denies nocturia, urgency, oliguria, polyuria, dysuria, or incontinence

Nervous System: denies loss of strength and weakness, seizures, headache, loss of consciousness, numbness, paresthesia

Musculoskeletal System: denies muscle or joint pain, swelling, arthritis

Peripheral System: *reports peripheral edema*, and denies intermittent claudication

Hematological System: denies anemia, easy bruising or bleeding, or lymph node enlargement

Endocrine System: denies polyuria, polydipsia, polyphagia, heat or cold intolerance or goiter

Psychiatric: denies depression, anxiety, seen a mental health professional, or use medications

**Physical Examination:**

General: 79 years old female is in patient gown w/appropriate hygiene, looks stated age, medium build, alert and oriented x 3, in no acute distress

Vital Signs: (vital signs took by Nurse Laura)

BP (supine, left arm): 135/71

HR: 89, regular

RR: 17, not labored

Temp: 98.2 F oral

O2 sat: 96% on supplement O2 via nasal canula

Height: not recorded weight: 138.4 lb

Skin: *Intact skin, warm and dry, poor turgor. A 2x3cm ecchymosis noted on the ventral aspect of left elbow and a 1x1.5cm ecchymosis noted on the dorsal aspect of left hand. Well healed scar extends from the right groin to the lateral hip, measuring approximately 13cm.*

Nails: No clubbing, capillary refill <2 seconds throughout.

Head: Normocephalic, atraumatic, non-tender to palpation throughout

Eyes: Symmetrical OU; sclera white; conjunctiva & cornea clear, EOMs intact.

Ears: Symmetrical. No discharge.

Nose: Symmetrical with no masses, lesions, deformities, or trauma.

Mouth and Throat: Lips are pink and dry, mucosa pink and moist, no masses/lesions noted, *missing 1 incisor on the upper side, and 1 premolar on the lower side.*

Neck: No masses, lesions or scars. Supple nontender to palpation. No bruits bilaterally or adenopathy

Chest: Symmetrical, no deformities, no trauma. Respirations unlabored. Nontender to palpation

Lungs: C*rackles noted on the bilateral lung fields. No wheezing.*

Heart: *S1, S2, grade 1 systolic murmur noted at right upper sternal border. No JVD*

Abdomen: Soft, not distended, bowel sound present in all 4 quadrants, nontender to palpation

Rectal: No examined

Female genitalia: No examined

Anus and rectum: No examined

Peripheral vascular: *No color change noted.* No calf tenderness. *No ulcerations. Bilateral lower extremity edema 2+, measure 15cm from lateral malleolus. Pulses are 2+ bilaterally in upper and lower extremities.*

Neurological:

Mental status: Alert and oriented x 3. Memory and attention intact.

Cranial nerve:

I - Not examined

II- Visual fields by confrontation full

III-IV-VI- Pupil equal, round, reactive to light, EOM intact

V- Facial sensation intact, strength good

VII- Facial movements symmetrical and without weakness

VIII- Hearing grossly intact to whispered voice bilaterally

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong

Motor/Cerebellar:

Full active and passive ROM of left upper and lower and right upper extremities without rigidity or spasticity, *right hip decreased flexion 60 degrees, right knee within normal range.* No tics, tremors or fasciculations. Strength appropriate for age, 4/5 on left upper and lower extremities, and right upper extremity, *and 3/5 on the right lower extremity*. *Able to stand w/o support for 15 sec*

Sensory: Intact to light touch, sharp/dull, and point localization bilaterally

Reflexes R L

Biceps 2+ 2+

Patellar 2+ 2+

Babinski negative negative

Musculoskeletal System: *Ecchymosis noted on left hand and left ventral elbow.* No soft tissue swelling, erythema, or deformities in bilateral upper and lower extremities. *Slight atrophy noted of right hip and right thigh compared to left side.* Nontender to palpation, no crepitus noted throughout. No spinal deformities

**Assessment:**

A 79 y/o female w/ PMHx of HTN, CHF, anemia, constipation, right hip fracture s/p ORIF was admitted to Margaret Tietz on 6/17/19 from NYPQ with a diagnose of decompensated CHF. She was admitted to Margaret Tietz for skilled rehab services, including oxygen supplement. Improved symptoms of CHF with increased Lasix dose and O2 sat stable on oxygen therapy; nonproductive cough is improving with less episodes; however, bilateral lower extremities edema still present; and constipation is worse since hospitalization. Long-term goal is for the patient to discharge to the community with home aide services in 2-3 weeks.

**Plan:**

* CHF

Continue Lasix 40mg PO BID

Continue Spironolactone 25mg QD

Continue oxygen therapy 2L via nasal canula

Assess/monitor cardiovascular status: monitor blood pressure and heart rate, O2 sat twice a day; and daily weight

Diet: restrict sodium intake, 2g maximum/day

Cough: continue observation, and add benzonatate if no improvement or worsen

Edema: elevation of legs as tolerated, and compression stocking

* HTN

Continue Lisinopril 10mg PO QD

Monitor blood pressure

* Anemia

Continue Ferrous 325mg PO QD

CBC every two weeks

* Constipation

Continue Colace 200mg PO QHS, and Glycolax 17g mix with 8oz water PQ QHS

Monitor bowel movements

Add Senna or enema if no bowel movement in 2 days

* Supplements

Vitamin C 500 mg PO QD and Multivitamin 1 tab PO QD

* Daily Multidisciplinary rehabilitation

Monitor vital signs, assist with ADLs, and ambulation

Pressure ulcer prevention: pressure reducing device for chair and bed; turning/repositioning Q2 hours

Fall precaution

Aspiration precaution

* Fall and safety precautions

Bed exit and personal alarm in place

Use bell for safety and help when needed-keep within reach

Bed at lowest position