CDI Clinical Scenario 1

CLINICAL DOCUMENTATION IMPROVEMENT:

An Introduction Into The Field of CDI

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

DISCHARGE SUMMARY

ADMITTED:
DISCHARGED:

ADMITTING DIAGNOSIS: Fever of Unknown Origin

DISCHARGE DIAGNOSES:

1. Bronchitis
2. Coronary Artery Disease
3. Hyperlipidemia
4. Anxiety/Depression
5. Hypertension
6. Gastroesophageal Reflux Disease
7. Renal Insufficiency
8. History of Right Bundle Branch Block
9. Osteoarthritis/Osteoporosis
10. S/P CABG
11. Bilateral Knee Replacements 1981
12. S/P Cholecystectomy
13. S/P Appendectomy

Patient presented to the ER with acute onset of fever and chills. Patient was admitted. He had a white count of 12.8 on admission which went up to 16.7 the following day. It subsequently resolved on the next day. Blood cultures were obtained as the patient was running temps of 103. These showed no growth over the period of 7 days. Chest x-ray revealed prominent lung markings without definite infiltrate. Patient was given IV fluids and IV antibiotics. He showed gradual improvement with her energy level coming back as well as her appetite. Fever resolved in about 24 hours. Patient was switched on oral antiobiotics 24 hours before discharged in preparation for discharge.

DISCHARGE MEDICATIONS

1. Cefzil 250 mg 1 po BID X 7 days
2. Potassium Chloride 20 mEq po q am
3. Lipitor 10 mg po q day
4. Elavil 50 mg po q hs
5. Protonix 40 mg po q day
6. Aspirin 81 mg po q day
7. Lasix 40 mg po q day
8. Univasc 7.5 mg po q day
9. Nitroglycerin .4 mg L SL q 5 minutes X 3, chest pain
10. Tylenol, 325 mg 1-2 po q 4-6 hours for fever, pain

CODING HOSPITAL

123 Main Street
Anywhere, USA

HISTORY AND PHYSICAL EXAMINATION

ADMITTED:

MEDICAL RECORD NUMBER:

HPI
Patient is a male who presents with about 1 ½ hours of severe chills. Patient has been hospitalized in the past for pneumonia on several occasions. He has been treated in the past when he experienced extreme respiratory difficulties and required steroids and antibiotics. Patient states he had been feeling well under sometime early this afternoon. Denies nausea or vomiting, denies diarrhea, cough, but does complain of some burning with urination.

PREVIOUS MEDICAL HISTORY:
Significant for CAD, Hyperlipidemia, anxiety/depression, HTN, GERD, renal insufficiency, history of right BBB, OA/OP, S/P CABG, knee replacement, cholecystectomy and appendectomy. Patient was hospitalized approximately 4 weeks ago for pneumonia.

CURRENT MEDICATIONS:

1. Vitamin E 400 U q am
2. Centrum Silver q day
3. Calcium with Vitamin D, 600 mg BID
4. Tylenol 1000 mg BID
5. Lipitor 10 mg q HS
6. Elavil 50 mg q HS
7. Protonix 40 mg q HS
8. ASA 81 mg po q day
9. Lasix 40 mg BID
10. Nitroglycerin .4 mg SL prn
11. Potassium Chloride 20 mEq po q am

ALLERGIES:
Codeine, Zithromax, Penicillin

ADMITTED:

MEDICAL RECORD NUMBER:

SOCIAL HISTORY:
Patient is married. Lives at home with wife. Has a lot of stress with family issues. Denies tobacco or alcohol use.

REVIEW OF SYSTEMS:
Patient denies any visual changes, cough cold, chest pain. Denies nausea, vomiting, diarrhea. His only complaints are dysuria and chills. BP 149/56, Pulse 97, Respirations 20. Temperature 99.8. Patient does not appear well and is chilling despite his normal temperature.

EXAM:

HEENT:	Pupils equal, round, reactive to light. Tympanic membranes clear, oral Pharynx clear
NECK:	Supple, no adenopathy, no JVD or carotid bruits
LUNGS:	Clear to auscultation
HEART:	Regular rate and rhythm, slight systolic murmur
ABDOMEN:	Obese, bowel sounds are present, abdomen soft, non-tender
EXTREMITIES:	Trace to 1+ bipedal edema. No clubbing, cyanosis noted Peripheral pulses are intact
NEUROLOGICAL:	Shows cranial nerves 2-12 intact

LABORATORY/X-RAYS
Chest x-ray essentially clear. May be mild cardiomegaly but no definite infiltrates. White count 12.8 with 81% segs, 12% lymphs. Hemoglobin of 14.9. Hematocrit of 43.9. Glucose is slightly elevated at 114. BUN 16, Creatinine 1.3, Sodium 139, Potassium 4.2, Chloride is 98. Carbon dioxide 31, Calcium 8.1, Total protein 8.6, Albumin 4.1, AST is 21, ALT 4, Alk Phos 158, Total bili is 7. Urinalysis shows clear yellow with a specific gravity of 1.010 and no evidence of leukocytes or bacteria. Glucose is negative, last WBC is 5.8.

ASSESSMENT/PLAN:
Will admit patient with fever of unknown origin. Will start of IV fluids and IV Claforan. If temperature becomes elevated above 101, will draw blood cultures. Will also repeat WBC in the AM.

PROGRESS NOTE

Date/Time

Patient states feeling quite tired, but no more chills. Denies cough, nausea or vomiting. Still complaining of dysuria.

Lungs, clear, Temperature up to 102. Abdomen soft with bowel signs.

WBC 16.7, 85.8% seg,

ASSESSMENT/PLAN:
Fever of unknown origin, cultures pending
Continue IV fluids and IV antibiotics, Will repeat UA due to symptoms

Patient ID

Admit:
MR #
Coding Hospital

PROGRESS NOTES

PROGRESS NOTE

Date/Time

Patient feels much better, not as fatigued, denies chest pain, SOB, denies any further symptoms of dysuria.

Vital signs stable, afebrile. Lungs, clear. Heart regular rate and rhythm.

ASSESSMENT/PLAN:
Fever of unknown origin. Will recheck CBC and repeat CXR. Switch to oral antibiotics this afternoon with possible discharge tomorrow if stable.

Patient ID

Admit:
MR #
Coding Hospital

PROGRESS NOTES

PROGRESS NOTE

Date/Time

Patient feeling well without complaints, ready for discharge. No symptoms, fever, chills, chest pain, SOB.

Lungs, clear, abdomen, positive bowel sounds, vital signs stable.

ASSESSMENT/PLAN:
Fever of unknown origin which has resolved. Patient has remained afebrile since switching to oral antibiotics over 24 hours ago. Discharge to home and follow-up in one week.

Patient ID

Admit:
MR #
Coding Hospital

PROGRESS NOTES

CODING REGIONAL HOSPITAL
Anywhere, USA

RADIOLOGY REPORT

MR#

DOB:

PA AND LATERAL CHEST,

Findings:
Lung markings are prominent without definite infiltrate identified. No change from x-ray taken 07/04/xx. Heart and pulmonary vessels are normal.

D:
T:

CODING REGIONAL HOSPITAL
Anywhere, USA

RADIOLOGY REPORT

MR#

DOB: 04/17/xx

PA AND LATERAL CHEST,

Findings:
Pulmonary markings are prominent without definite infiltrate identified. No change from 08/11/xx. Heart size is normal.

D:
T: