CDI Clinical Scenario 5

CLINICAL DOCUMENTATION IMPROVEMENT:

An Introduction Into The Field of CDI

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

User: F
Hospital: 0004

Clinical View Notes Report

Date Range: 12/06/16 11:10 - 12/13/16 11:10

Date: 12/13/16
Time: 10:10

Patient Name:	Room / Bed:	HSV:	MIP
Patient #. [redacted]	DOB:	Admitted:	
Medical Record [redacted]	Age / Sex	Discharged:	[redacted]

Date	Time	By / Note Text
12/08/16	1204	- nurse regarding possible change of admission status to SWB. Was given the same fax# I used to send clinicals - told to compose a letter requesting this change. A letter was typed, sent to [redacted] her input and faxed to [redacted] with additional reference to our call of [redacted]. Faxed updated clinicals as well. Per Katherine - clinicals could take up to 72 hours for authorization. Informed [redacted] of the same - change in admission status will not be done until we hear back from them.
12/08/16	0949	Progress Note S: patient is feeling better today. He would like his Lyrica restarted and complains only of rib pain. His cough is improving and his dyspnea is only with exertion. He is using the incentive spirometry. O: T 98.2, P 99, R 20, BP 133/44, O2 96% on 2L but dropped to 88% with ambulation. Scruffy male in NAD in chair, Right scalp hematoma with sutures slightly tender, neck supple, Lungs with coarse rhonchi on the right and rales bases, CV S1 and S2 irreg with 3/6 SEM, abdomen soft, Extremities trace edema Na 132, K 3.9, BUN 26, Cr 1.66, Blood sugar 200's to 348, WBC 14.2, Hct 29.7, Plt 140, BC with staph aureus no sensitivities yet, CXR - single view with CHF and pleural effusions Ass: Pneumonia, slowly improving, Staph Aureus on blood culture ? contaminant, CHF, Deconditioning Plan: continue IV antibiotics and add one dose Vanco until we get sensitivities, check echo, give IV lasix and potassium, restart Lyrica, continue PT, will need skilled nursing
12/07/16	2023	Progress Note S: patient states he continues to cough and have right chest pain with cough and movement. He is feeling a little better. He was able to get up to a chair and received incentive spirometry instructions. He is eating well. O : 98.1, P 80, R 18, BP 108/48 alert male in NAD Neck supple, LUngs with rhonchi mostly right side, CV S1 and S2 with 3/6 SEM irreg, Abdomen soft, Extremities trace edema CXR PA and Lat - intersstitial edema consistent with CHF, Na 131, K 4.1, BUN 21, Cr 1.59, WBC 15.5, Hct 29.5, Plt 127, Iron less than5, BS 189, Monitor with ectopy and one three beat V Tach asymptomatic after aerosol treatment Ass - Pneumonia, CHF, Blood Loss Anemia with Iron Deficientcy, Hyponatremia improving Plan - Lasix, monitor lytes, incentive spirometry, continue Rocephin and Azithromycin, check I and O's recheck CXR in AM
12/07/16	1529	- nurse Case Management Faxed clinicals to BCBS -
12/07/16	1520	nurse SUPERVISOR Blood culture gram positive cocci in clusters called to
12/06/16	2235	H+P History and Physical Date of Admission: 12/6/2016 Chief Complaint: Confusion and Fever History of Present Illness: This 88 year old states he stumbled and fell several days ago when his trash can on wheels got away from him. He hit his head on the right side and his right ribs. He was dazed but did not lose consciousness. He did not immediately seek help but after his head wound bled through many towels he came to the ER yesterday and had sutures of his parietal laceration, no intracranial bleed on CT head and ? old right posterior rib fracture (likely recent by history). He was given Percocet for pain and went home. He returned today and has likely taken 7 Percocet tablets and is confused and has a fever and congested

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12/06/16	2235	cough and pain in the right ribs. He has dyspnea with coughing. Allergies: None Medications: Glyburide 2.5 mg BID, Lipitor 40 mg daily, Plavix 75 mg daily, Pletal 100 mg bid, Synthroid 100ucg daily, Lyrica 150 mg bid PPH: Medical History: CAD, PVD, DM, Neuropathy Left arm, AAA, Benign LUng Tumor, Skin Cancer, Hyperlipidemia Surgical History: Thoracotomy right, CAB, AAA resection, Fem-Pop Bypass, Cataract extraction Family History: Father died of Colon Cancer, Mother deceased and had DM Social History: lives with his wife on Alcohol: daily 1/2 goblet of Cognac Tobacco: 2 cigars daily Illicit Drugs: denies ROS: Constitutional-negative for unexplained weight change,change in appetite Positive for fever, chills and sweats HEENT- negative for change in vision, double vision, glaucoma, corrective lenses, sore throat, nosebleed, hearing loss, tinnitus, dry mouth/eyes, voice change. Positive for sinus congestion, dentures Neck- negative for pain, swelling, lymph nodes Pulmonary- see HPI Cardiovascular-negative for palpitations, swelling of the ankles, claudication, venous disease. GI- negative for nausea, vomiting, diarrhea, constipation, abdominal pain, melena, hematochezia, GERD, dysphagia. GU- negative for frequency, dysuria, hematuria, incontinance. Musculoskeletal-negative for joint pain, joint swelling, myalgia, limited motion, back pain. Neurological-negative for headaches, dizziness, vertigo, paralysis, gait change, memory loss, Positive for neuropathy left arm and both feet Hematological-negative for swollen glands. Positive for bleeding and bruising Skin- negative for rash, itching, moles, hair loss. Endocrine-negative for polyuria, heat intolerance, cold intolerance, thirst. Allergy/Immune-negative for hives, anaphylaxis, rhinitis. Psychiatric-negative for anxiety, depression, suicidal ideation, insomnia.
12/06/16	2224	Physical Exam: VS: BP: 140/65 HR:105 RR: 20T: Sat: 94%Wt:194 Ht: 71 General- 88 year old with congested cough slightly confused HEENT-PERRL, EOM intact, TM clear and flat, Nose with sinus congestion, Oropharynx clear with moist mucous membranes. No dentition, right parietal scalp hematoma with sutures Neck-supple, no thyromegaly, no lymphadenopathy, no carotid bruits. Chestno lumps, no discharge, positive for tenderness right posterior ribs Lungsrales and rhonchi right especially RLL with congested cough CVS1 and S2 irreg with SEM 3/6 aortic area, distal pulses faint Abdomensoft, no tenderness, distended and tympanic, BS active, no guarding, no rigidity Musculoskeletalno joint swelling, no joint deformity, no limitation of motion, no spinal tenderness. Extremitiesno edema, no clubbing, no cyanosis. Neurologicaloriented x3, cranial nerves intact, motor intact, sensory intact, reflexes intact, gait normal, memory intact. Skin - no rash, no abnormal moles. Superficial laceration right lower leg without erythema Psychiatricmood stable Lymphaticno lymphadenopathy.

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Date	Time	By / Note Text
12/06/16	2224	

Labs: Na 127, K 3.8, BUN 18, Cr 1.57, Glu 247, Albumin 2.9, WBC 14.5, Hct 31.1, Plt 137, TSH 2.49, U/A with RBC, Flu negative
Imaging: CT head external right parietal hematoma without intracerebral bleeding, CXR and ribs with chronic changes and ? old right posterior rib fracture
ECG: sinus with first degree AV block and IVCD
Provisional Diagnosis: 1.Pneumonia, following rib contusion/fracture
2. Hyponatremia,
3. Confusion with Head Injury
4. Diabetes Mellitus
5. CAD
6. Percocet ingestion
7. Neuropathy Left Arm
8. Hypothyroid
9. PVD
Planned Treatment: Patient will be admitted to inpatient on telemetry. He will receive IV NS to treat electrolytes and rehydrate. He likely has blood loss anemia from profusely bleeding scalp laceration from anticoagulants and iron panel will be checked. He will be on his hypoglycemics and blood sugars will be monitored. He had blood cultures and urine culture in the ER and has received Rocephin 1 gram. He will also receive Azithromycin 500 mg every 24 hours and will have repeat chest xray in the AM to see if rehydration will demonstrate RLL pneumonia. Electrolytes will be monitored. Will hold Lyrica for now since he took 7 percocet in the last 24 hours.

[redacted]

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Hospital: 0004

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Patient #:	[redacted]	DOB:	[redacted]	Admitted:	[redacted]
Medical Record	[redacted]	Age / Sex:	[redacted]	Discharged:	[redacted]

Date	Time	By / Note Text
12/11/16	1041	Plan: patient is no longer improving and needs to be transferred to a higher level of care due to Pneumonia, CHF and declining renal function, call placed to [redacted]ansfer center and discussed with patient and his wife. Discussed with patient if he needed a ventilator would he want that? He states that would be OK if it would help. Patient remains a full code.
12/11/16	1012	SPOKE WITH [redacted] TRANSFER CENTER, REQUESTING TRANSFER FOR PULMONOLOGY, CARDIOLOGY, AND RENAL. CLINICALS, FACESHEET, TRANSFER ORDER FAXED
12/10/16	1219	Progress Note S: patient requested to stay here and not be transferred if possible. He is a little better every day, but his appetite falls off late in the day. He continues with congested cough but has done some walking and is up to the chair. No BM for 4 days O: T 97.8, P 106, R 20, BP 132/49 94% on 3L, alert male in NAD with congested cough, Lungs with diffuse rhonchi and rales at the right base, CV S1 and 2 tach and irreg, Abdomen slightly distended and soft, Extremities without edema Chest Xray with RLL infiltrate and effusion and ACHF Na 132, K 3.6, BUN 39, Cr 2.02, Glu 189, WBC 14, Hct 27, Plt 202 Ass: RLL Pneumonia, CHF with cardiomyopathy (30% EF) Plan: IV lasix and then will start po dose tomorrow, watch as BUN and creatinine have been going up, continue Xopenex, BS coverage, IV antibiotics, add nutritional supplement if he isn't eating well
12/09/16	1341	- nurse Case Management Received a call from [redacted]. She states he is a "borderline" case for acceptance @ [redacted] d/t his ambulating 200 ft this am. States [redacted] can do a peer to peer review. Spoke with [redacted] - she states we can hold off on the transfer as he seems to be improving. Called Marla and updated her as well - her concern is that if we decide to transfer later or tomorrow - she will not have the authorization d/t the weekend. Informed [redacted] of the same. Phone # to contact BCBS for peer to peer is 866-309-1719, option 3 - use ref #8327414 for inpatient stay and if swing bed is discussed -
12/09/16	1007	[redacted] Case Management Faxed updated clinicals to BCBS
12/09/16	0920	Progress Note S: patient was tired late yesterday but slept well. He feels a little better today. He was tired after he walked with therapy but he was able to get up and walk the halls and his sat was 96% on 3 L after walking. He continues with congested cough and right rib pain O: T 99, P 113, R 20, BP 120/57, O2 sat 97% on 3 L Alert gruff male in NAD with thick cough, scalp wound healing right parietal, neck supple, Lungs with diffuse rhonchi, CV S1 and S2 irreg and tachy, abdomen soft, Extremities trace edema 2D echo - EF 30% with mild aortic stenosis, CXR last evening with mild CHF unchanged, BS 162-168, Na 132, K 4.2, CO2 25, Cl 98, BUN 29, Cr 1.82, WBC 17.9, Hct 30%, Plt 176, blood culture MSSA (likely contaminant) Ass: Pneumonia S/P Rib contusion, CHF with ischemic cardiomyopathy, DM, Deconditioning Plan: Albuterol changed to Xopenex due to tachycardia, will add Lisinopril, Lasix IV last night and today, monitor lytes and repeat CXR tomorrow, continue PT and incentive spirometry, Rocephin and Azithromycin IV, will look into SNF versus Acute rehab
12/08/16	1204	Case Management [redacted], option #3. Spoke with representative -

[redacted]

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Date	Time	By / Note Text
12/12/16	0947	will call this HS back with administrator's name and approval. Call dispatch to request [redacted]HS. They are currently transporting another pt and [redacted]ifeNet to give heads up and request for transport.
12/12/16	0943	SUPERVISOR At 9:05 today this HS called Transfer center for Kendall Regional. Spoke to [redacted] for pulmonology/ cardiology. All clinicals and demographic info faxed to (305) 229-2406.
12/12/16	0846	· nurse Case Management Called BCBS @ 866-309-1719, option 3. On hold for 15 minutes, spoke with representative Felicia who informed me to get authorization for a transfer to acute care facility - fax# 866-464-8223 - can take 48-72 hours. Questioned about an emergency transfer - will indicate on cover sheet the emergency of this transfer. Informed Dr. · of the same, he is requesting to speak with a medical director, or someone to expedite this transfer. Faxed abstract of chart.
12/12/16	0745	SUPERVISOR Spoke to [redacted] RN and gave her the information requested by Baprtist in order to transfer pt.
12/12/16	0742	SUPERVISOR Spoke [redacted]t transfer center. States we need to cpontact BCBS [redacted] with NPI # for Baptist and for FCH and diagnosis ICD 10 code.
12/11/16	1404	[redacted] FROM BAPTIST CALLED AND GAVE ME THE ANSWERING SERVICE NUMBER FOR [redacted]
12/11/16	1329	SPOKE WITH [redacted] AND THEY ARE WANTING AUTHORIZATION FROM BCBS BEFORE TRANSFERING [redacted]T IS GOING TO CONTINUE WORKING ON TRANSFER.
12/11/16	1255	Addendum - I spoke with the transfer center and they state that they need insurance approval before they will accept the transfer! Patient may be a little dry at this point because the original weight of 194 pounds was not a measured weight but based on what the patient told the staff. He has been up to 216 and today 209 with BUN and Creatinine climbing. I will hold off on further IV lasix and switch to po. We will push fluids and supplements and see where we stand tomorrow. His infectious parameters are improved in that he is now afebrile and WBC count is coming down so I will not change the antibiotics (Ceftriaxone and Azithromycin). We will try to get him up and moving more.
12/11/16	1218	CALLED [redacted] UPDATE ON TRANSFER AN[redacted]VAS ON PHONE AND I WAS TOLD SHE WOULD CALL ME BACK.
12/11/16	1041	Progress Note S: Patient today states he doesn't feel as well. He is very tired and dyspneic. He has no appetite, and doesn't want to get up. O: T 98.8, R 23, P 117, BP 126/49, Sat 95% on 3 L, Weight 208 (admission 194) patient appears pale and tired but knows me, congested cough, Lungs with rales right base and diffuse rhonchi, CV tachy and irreg iwth systolic murmur, Abdomen soft, Extremities without edema Na 133, K 36., BUN 47, Cr 2.23, WBC 13.5, Hct 27, Plt 259, CXR yesterday with R mid to lower lobe infiltrate and pulmonary venous congestion, BS 213, urine output 350 7 PM and 250 4 AM Ass: Pneumonia, Blood loss Anemia, CHF with EF 30%, ARF on CKD

User:
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12/12/16	1729	SUPERVISOR Called [redacted] to cancel request for transfer. Informed pt has been accepted to Mt Sinai.
12/12/16	1646	SUPERVISOR Received a call from [redacted] PT has been accepted by Dr. [redacted] will go to step down room # 735 bed 1. Report to be called to 305 674 2870. Trauma Star called. S. Phipps RN confirmed they can transport pt. ETA 20 min.
12/12/16	1449	SUPERVISOR Spoke to [redacted]hai. States she is working on transfering pt. She will call back with update in a while.
12/12/16	1443	nurse Case Management Emailed our BCBS representative - for assistance in getting authorization for this patient who needs transferred for Pulmonolgy and Renal - he is out of the office, but emailed me back the 800 # for provider care services - which I have attempted to call twice - waiting on hold for greater than30 min, only to be disconnected. Attempted to call the number given to me by Elaine @ Baptist transfer center - [redacted] - was transferred to another rep and was told that this member is not a Florida Blue member. Called Elaine back - she requests I send her more updated labs, CXR - done. She feels he may be appropriate for West Kendall Baptist - but authorization still needs to be done by us. Explained to her the problem we are having in Avility - receiving facilities are not listed. She gave me the on call renal and pulmonologist - Dr. wishes to let Kendall Regional take the patient as we have acceptance from their cardiologist - Dr. [redacted] Discussed this issue with [redacted]O. Faxed and spoke with MSMC bed control as well and faxed abstract of chart.
12/12/16	1250	SUPERVISOR Called pt's spouse to ([redacted] No answer- left a message to call this HS for update on transfer process.
12/12/16	1217	- nurse Case Management @ 1120 I called Provider Services @ [redacted] and was on hold for 30 minutes. Rep Susan came on and informed me that this was not a Florida Blue member and transferred me to another extension to route the call - I then was on hold for an additional 10 min, only to be disconnected. I then called BCBS @ 866-309-1719, option 3 once again to inquire for Dr. - to speak with a medical director - spoke with LeAnne - she states there is no medical director there. Preferred method is EPA - informed her I had faxed earlier request for authorization for this emergent transfer - she states the only method is fax or Avility - called Yani @ 6422 - left a message, called Thania in ER registratrion - she referred me to Carrie @ 6430 - left a message with her as well.
12/12/16	1213	SUPERVISOR Reciprocal agreement sent to [redacted]ndall transfer center to [redacted]
12/12/16	1048	SUPERVISOR Spoke to [redacted]er administrator on call needs to have the BCBS approval prior to accepting pt on transfer. As soon as it is approved, pt can go.
12/12/16	0947	SUPERVISOR Received a call from . Pt has been accepted by [redacted] should go by air. Pending administration approval.

ECHOCARDIOGRAM

PATIENT: **DOB:**
MED REC: **ACCOUNT#:**
ADMIT DATE: **DISCHARGE DATE:**
LOCATION: **ROOM:** **BED:** **DICTATING:**

ATTENDING:

DATE OF STUDY: 12/08/2016

TYPE OF STUDY:
A 2D echocardiogram with Doppler.

AGE OF PATIENT:
88.

SEX:
Male.

DATE OF BIRTH:
03/24/1928

REFERRING PHYSICIAN:

CLINICAL INDICATION:
Chronic systolic congestive heart failure.

HEIGHT:
5 feet 11 inches.

WEIGHT:
196 pounds.

2D, M-MODE AND COLOR DOPPLER ECHOCARDIOGRAM:
M-Mode dimensions:
Aortic root 3.4 cm.
Left atrium 4.4 cm.
Left ventricle end diastole 6.7 cm.
Left ventricle end systole 5.4 cm.
Right ventricle end diastole 1.7 cm.
Left atrial volume index 26 mL/m2.
Right atrial area 18 cm2.
Right atrial length 48 mm.
Right atrial dimension 36 mm.

PATIENT: **DOB:**
MED REC: **ACCOUNT#:**
ADMIT DATE: **DISCHARGE DATE:**
LOCATION: **ROOM:** **BED:** **DICTATING:**

ATTENDING:

Interventricular septum 1.5 cm.
Left ventricle posterior wall 1.3 cm.
Fractional shortening 19 percent.
Left ventricular ejection fraction 30 percent.
E/E prime ratio 9.

TECHNICAL QUALITY:
Good.

IMPRESSION:

1. Severe left ventricular enlargement with moderate-to-severely reduced systolic function. The basal inferior wall and basal inferolateral wall appear akinetic. The rest of the left ventricle appears hypokinetic with dyssynergic motion. Mild-to-moderate concentric left ventricular hypertrophy. Left ventricular ejection fraction is estimated to be 30 percent. Grade 1 left ventricular diastolic dysfunction.
2. Normal right ventricular size and systolic function.
3. Mild left atrial enlargement measuring 4.4 cm.
4. Normal left atrial volume index.
5. Normal right atrial size.
6. No evidence of intracavitary mass or thrombi.
7. Normal size aortic root with calcification.
8. Normal mitral valve with trace mitral regurgitation. No evidence of mitral valve prolapse or mitral stenosis.
9. Trileaflet aortic valve with mild aortic stenosis with peak aortic valve velocity of 2.3 m/second, peak aortic valve gradient of 21 mmHg, and mean aortic valve gradient of 11 mmHg with aortic valve area of 2.6 cm2. No evidence of aortic regurgitation.
10. Normal tricuspid valve with trace tricuspid regurgitation. No evidence of tricuspid stenosis.
11. The pulmonic valve is not visualized. There is increased peak pulmonic valve velocity of 1.4 m/sec suggestive of mild pulmonic stenosis. No evidence of pulmonic regurgitation.
12. No evidence of valvular vegetations.
13. Moderately dilated inferior vena cava with normal respiratory collapse.
14. Unable to assess pulmonary artery systolic pressure.
15. Normal pericardium. No evidence of pericardial effusion.

CONCLUSION:

1. Severe left ventricular enlargement with moderate-to-severely reduced systolic function. The basal inferior wall and basal inferolateral wall appear akinetic. The rest of the left

PATIENT:		**DOB:**	
MED REC:	000059362	**ACCOUNT#:**	
ADMIT DATE:	12/06/2016	**DISCHARGE DATE:**	
LOCATION:	**ROOM:** [redacted] **BED:**	**DICTATING:**	

ATTENDING:

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ventricle appears hypokinetic and dyssynergic. Mild-to-moderate concentric left ventricular hypertrophy. Left ventricular ejection fraction is estimated to be 30 percent. Grade 1 left ventricular diastolic dysfunction.

2. Mild left atrial enlargement by dimension measuring 4.4 cm.
3. Normal left atrial volume index.
4. Normal size aortic root with calcification.
5. Trace mitral and tricuspid regurgitation.
6. Mild aortic stenosis with peak aortic valve velocity of 2.3 m/second, peak aortic valve gradient of 21 mmHg, mean aortic valve gradient of 11 mmHg and aortic valve area of 2.6 cm2.
7. Mild pulmonic stenosis with peak pulmonic valve velocity of 1.4 m/sec.
8. Moderately dilated inferior vena cava with normal respiratory collapse.
9. Unable to assess pulmonary artery systolic pressure.
10. No evidence of intracavitary mass, thrombi, valvular vegetation, or pericardial effusion.
11. A previous exam is not available for comparison.

Signed:_____

DD:
DT:

CC: