CDI Clinical Scenario 8

CLINICAL DOCUMENTATION IMPROVEMENT:

An Introduction Into The Field of CDI

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

CODING HOSPITAL

123 Main Street
Anywhere, USA

HISTORY AND PHYSICAL EXAMINATION

ADMITTED:

MEDICAL RECORD NUMBER:

Patient Name:
Date of Admission:
Date of Birth:

CHIEF COMPLAINT: Weakness

HISTORY OF PRESENT ILLNESS:
Patient is a 44 year old male who is known non-insulin dependent diabetic who is living at home. Apparently he developed cough and increasing weakness about 48 hours prior to admission. It is uncertain whether he had any fever at home but because of the increasing weakness he was unable to get out of bed. He was brought to the emergency room and found to be in significant respiratory distress and fairly unresponsive. He was a very poor historian because he really did not answer many questions at all. He was found to be in atrial fibrillation with a blood sugar over 500. He was given Digoxin IV in the emergency room as well as put on a diltiazem drip which improved his rate somewhat however his blood pressure came down to around only 100 systolic. He however was somewhat improved and was admitted to the coronary care unit.

PAST MEDICAL HISTORY:
History of NIDDM, peptic ulcer disease, degenerative arthritis. Previous surgeries: 1998 right lung lobectomy, 1983 TURP, 1994 cholecystectomy. Other hospitalizations for hepatitis secondary to sulfa reaction.

Allergies to sulfa.

CURRENT MEDICATIONS:
Glucophage 500 mg two with breakfast, one with lunch, two with supper, Glipizide 10 mg pot id.

SOCIAL HISTORY:
Does not smoke or drink alcohol. Caffeine occasionally.

ADMITTED:

MEDICAL RECORD NUMBER:

FAMILY HISTORY:
He had a sister, brother and cousin with diabetes. He also had a brother with multiple myeloma. He has one brother with CHF. No family history of atherosclerotic heart disease.

REVIEW OF SYSTEMS:
Not obtainable at this time

PHYSICAL EXAMINATION:

General:	Male who is pale, diaphoretic, occasionally mumbles but no Intelligible responses with verbal stimuli
Head:	Normalcephalic. Eyes, pupils not related secondary to cataracts. No obvious fundoscopic changes. TMs clear, mucuous membranes Are tacky.
Neck:	Supple, No adenopathy or thyromegaly.
Chest:	Decreased breath sounds on the right where he had surgery. The left side Reveals scattered rhonchi as well as transmited upper airway sounds. No rales, labored breathing.
Cardio:	Distant heart sounds. Irregular rhythm. SI and S2, no murmurs. No JVD. No carotid bruits. Carotid pulses +1 bilaterally, no abdominal bruits.
Rectal:	Not done
Extremities:	No peripheral edema. Pedal pulses 2+ bilaterally.
Neuro:	Difficult to assess due to his marked somnolence.

IMPRESSION:

1. Lower respiratory infection, probable influenza with fairly significant respiratory distress.
2. Insulin dependent diabetes, poor control with blood sugar over 500. Recommend insulin sliding scale.
3. Atrial fibrillation. Rate is better controlled. He is on diltizem drop which we will taper. He is given IV nitroglycerin. We will also continue his 100% oxygen and plan on treating him while in the hospital with medical and supportive therapy.

Patient is DNR, DNI.

D:
T:

PROGRESS NOTE

Date/Time

TREATMENT NOTE

Respiratory

Patient seen for 2.5 mg Albuterol nebulizer treatment. Tolerated passively. Treatment done with mask. Breath sounds absent on the right, decreased on the left with rales in base. Slight increase in aeration with nebulizer. No cough.

Patient ID

Admit:

PROGRESS NOTES

MR#
Coding Hospital

PROGRESS NOTE

Date/Time

Patient really not improving. Given IV Lasix 80 mg IV for poor output. Has developed hypotension 73.43 now and coarse crackles are heard throughout the lung fields.

We will attempt to control with a "renal dose" of dopamine and see if his condition improves.

Patient ID

Admit:

PROGRESS NOTES

MR#
Coding Hospital

PROGRESS NOTE

Date/Time

PROGRESS NOTE:

02/19/XX

Patient continues to deteriorate. Prognosis poor. Virtually no response to dopamine. Remains unresponsive, more difficult to arouse. Severe dehydration. Spoke with family regarding status and they wish to abide by his DNR, DNI orders.

We will continue supportive measures and see how patient does.

NURSE NOTE:

02/19/XX

Patient experiencing severe respiratory distress. DNR, DNI order in place. Will continue to support patient. Physician advised.

Time of death 02/19/XXXX 11:35 PM

Patient ID

Admit:

PROGRESS NOTES

MR# .

Coding Hospital

PROGRESS NOTE

Date/Time

TREATMENT NOTE

Respiratory

Patient seen at 1450 for nebulizer with 2.5 mg Albuterol unit dose. Tolerated passively. Breath sounds increasingly coarse with rales and crackles heard throughout. Patient has deteriorated since treatment on 01/17/xx. Physician advised.

Patient ID

Admit:

PROGRESS NOTES

MR#

Coding Hospital

CODING REGIONAL HOSPITAL

Anywhere, USA

RADIOLOGY REPORT

MR#

DOB:

CLINICAL SUMMARY: Patient unresponsive. Low O2 saturation.

PA AND LATERAL CHEST, 02/18/XXXX

Findings:

Comparison with study of 02/02/XXXX. There has been no change in appearance of the chest. Patient apparently had a right pneumonectomy with complete opacification of te right hemithorax and the heart and mediastinal structures deviate into the right chest. Pleural calcifications are seen in the right hemothorax. The left lung remains clear and fully expanded, although there are some patchy areas of atelectasis at the left lung base. There is considerable motion artifact. I cannot totally exclude the possibility of an early infiltrative process at the left lower lobe and if clinical symptoms persist, I would suggest an attempted follow up study.

IMPRESSION:
The residual left lung appears clear. The questionable findings at the left lung base may be related to motion artifact. If clinically indicated, follow up exam should be performed.

D:
T: