CDI Clinical Scenario 10

CLINICAL DOCUMENTATION IMPROVEMENT:

An Introduction Into The Field of CDI

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

PATIENT NAME:
PATIENT NO:
HOSPITAL NO:
PHYSICIAN:
D.O.B.

ADMISSION DATE:

Discharge Summary

DATE: 01/24/2016

DATE OF ADMISSION: 01/22/2016

DATE OF DISCHARGE: 01/24/2016

DISCHARGE DIAGNOSES:
1. Aspiration pneumonia
2. Hypoxia
3. Seizure disorder
4. Schizophrenia
5. Dementia
6. COPD exacerbation
7. Tobacco use

CONSULTS: Did discuss his case with the hospitalist at regarding a previous admission where he was intubated for decreased level of consciousness from a large amount of Versed given for seizure control.

PROCEDURES: None.

IMAGING: Chest x-ray showing right lower lobe infiltrate.

PERTINENT LABS: White blood cell count on admission 13.8, white blood cell count yesterday 14.5, refused labs today. Creatinine mildly elevated at 1.55, BUN 21, potassium 3.3 on admission and now 3.5 but unable to get labs today.

ALLERGIES: SULFA, LEVETIRACETAM, DIVALPROEX ACID although he is currently on Depakote so I question that allergy.

BRIEF REVIEW OF ADMISSION: is a 70-year-old gentleman who was rushed by ambulance from his Country Acres home because of marked hypoxia. He presented on a 10L rebreather with an O2 sat of 82%. It was assumed that he perhaps aspirated. He was given hydrocortisone IV in the emergency room and nebulizer treatments and his oxygen saturation improved to about 90% on 2-3 L. I discussed his case with the hospitalist to understand his previous hospitalization at ıospital for two weeks where he was intubated. He is DNR/DNI. Apparently he was intubated because he was unable to breathe due to medication given for his seizure, not because of his COPD. Because he did not improve in the emergency room we opted to keep him here, treat him with IV antibiotics in the form of Zosyn for aspiration pneumonia. We treated him with Solu-Medrol which he ultimately refused after a couple of

Discharge Summary	PATIENT NAME: PATIENT NO: HOSPITAL NO: PHYSICIAN: D.O.B. ADMISSION DATE:

doses and then treated him with oral prednisone. He has difficulty taking medications, medications need to be disguised in pudding or applesauce, particularly his seizure meds as he has had some grand mal seizures for refusing to take his medications. Fortunately his Depakote level was therapeutic so he is getting adequate Depakote. Discussed his case with his caregivers and they recommended liquid antibiotics at discharge.

ON EXAM his lungs reveal occasional rhonchi but for the most part much clearer. He is alert, oriented, breathing much better. His heart is regular. Vital signs are all stable with a temperature of 97.4, respirations 24, blood pressure 124/81, O2 sats on room air 94%, and his caregivers state that he typically runs an O2 sat of 90% at Country Acres. His T-max was 101.3 and that was on 01/23. He started to feel more agitated as he typically does so it is time to move him back to his more familiar environment.

DISCHARGE MEDICATIONS will be:

1. Augmentin 400 mg/57, two teaspoons b.i.d. for 8 days
2. Prednisone 20 mg b.i.d. for 5 days
3. Albuterol nebulizers
4. Lorazepam 1 mg t.i.d.
5. Seroquel 50 mg three times daily
6. Milk of Mag p.r.n.
7. Norvasc 5 mg daily
8. Zofran p.r.n.
9. Acetaminophen

He can follow up with his doctor in Shell Lake per his MD or in the next week. He is DNR/DNI.

D: 01/24/2016 1026 T: 01/25/2016 1028
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02/02/16 12:41

EMERGENCY ROOM RECORD	PATIENT NAME: P PATIENT NO HOSPITAL NO: PHYSICIAN: D.O.B. DATE:

DATE: 01/22/2016

CHIEF COMPLAINT: Shortness of breath.

HISTORY OF PRESENT ILLNESS: Patient in with extreme shortness of breath brought in by ambulance. He is very difficult to understand. He apparently got worse quickly today. He was given a Duoneb while in the ambulance which helped minimally. Patient has underlying history of COPD. There is no evidence of recent increased fluid retention or weight gain.

PAST MEDICAL HISTORY
ALLERGIES: SULFA, HCTZ, LEVETIRACETAM, DIVALPROEX.

MEDICAL PROBLEMS:
1. Psychiatric history, schizophrenia.
2. Seizure disorder.
3. Osteoarthritis.
4. Hyperlipidemia.
5. Dementia.
6. COPD.

SOCIAL HISTORY: A smoker; currently lives in a group home.

EXAM: Afebrile; pulse 130; respirations 42 and labored; BP 195/100; sats 88% on 10 liter nonrebreather. His lungs sound loud and rhonchorous, scant expiratory wheeze noted. He is somewhat disheveled but notable increased work of breathing. His abdomen is soft, scaphoid. Extremities: trace edema.

EMERGENCY ROOM COURSE: He was given 100 mg of hydrocortisone IV along with 40 mg of IV Lasix along with his oxygen. He was given ½ mg of Ativan. He continued to remain somewhat agitated although the Ativan was helpful. He was given another Albuterol nebulizer. He did not stabilize to normal but he did moderately improve.

Chest x-ray showed shaggy right heart border, possible infiltrate.

LABS showed a white count of 13.8, hemoglobin 12.1, potassium low at 3.3, glucose 147, BNP was normal at 32, creatinine 1.32, BUN 16. Blood culture pending.

ASSESSMENT:
1. COPD exacerbation and respiratory distress.

EMERGENCY ROOM RECORD	PATIENT NAME: P PATIENT NO HOSPITAL NO: PHYSICIAN: D.O.B. DATE:

2. Underlying mental status may make treatment difficult as he was reluctant to take his medications.

PLAN. Dr. came in and accepted patient for admission. He remains DNR/DNI at this time. Antibiotics will be started as well.

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HISTORY AND PHYSICAL	PATIENT NAME: PATIENT NO: HOSPITAL NO: PHYSICIAN: D.O.B. DATE:

DATE: 01/22/2016

Mr. is a 70-year-old gentleman who presented to the emergency room by ambulance acutely short of breath and hypoxic. He presented with a 10 liter rebreather with an 83% oxygen saturation. I admitted him in June of 2014 with a similar episode, similar oxygen saturations. He responded to Lasix although his BNP was normal, and he responded to oxygen and Solu-Medrol and nebulizer treatments so that now he is satting right around 93% on 2 liters according to the home he lives in. He is normally 90% on room air. I contacted his brother because his brother wanted us to call him with our plans. His brother told us that his was admitted to Hospital over Christmas and was hospitalized for two weeks for pneumonia and was intubated for four days. His advanced directives per the Country Side Acres stated that he is DNR/DNI. I did ultimately contact Hospital and spoke with the hospitalist there who could give me some information in regards to his admission. She states he was intubated briefly because he had a grand mal seizure, was treated with 9 mg of Versed and stopped breathing. For that reason his breathing was supported by intubation. He was extubated quickly. He did not have COPD exacerbation. Apparently his arterial blood gases were fairly good. Apparently was treated for pneumonia. He stayed there a long time primarily because of his seizure control, issues with swallowing, and maintaining medications. Apparently he was difficult to care for there. There he did sign his advanced directives as being DNR/DNI. At this point given that he is stable from an oxygen standpoint and his oxygen saturations have improved and he is currently not in status epileptic, I think we could safely keep him here and the hospitalist at felt that he was stable to stay here, did not require transport.

He is a very difficult historian. In fact, he cannot give me history at all; he moans and groans. He does open his eyes. He is very cooperative.

He has a HISTORY of:

1. Seizure disorder with recent grand mal seizures, apparently been hospitalized twice, once at Regions and once at St. Croix.
2. He has schizophrenia.
3. Dementia.
4. Cervical spondylosis.
5. He does not have Parkinson's disease per the hospitalist.
6. Esophageal dysmotility which may likely result in aspiration pneumonia throughout.
7. History of thrombocytopenia.
8. Gait abnormality.
9. Tobacco use.

HISTORY AND PHYSICAL	PATIENT NAME: PATIENT NO: HOSPITAL NO: PHYSICIAN: D.O.B. DATE:

CONSULTS: I did discuss his case with the hospitalist at Hospital.

ALLERGIES: SULFA; KEPPRA; DIVALPROEX, although he is currently on Valproic acid.

PAST SURGICAL HISTORY is significant for multiple cystourethroscopies most recent in April 2015.

FAMILY HISTORY is noncontributory. He does not see Dr. He is followed in Shell Lake.

IMMUNIZATIONS: I am unaware of where his immunization status is. He has had a Pneumovax in 2012, Tdap in 2012. I am not certain if he has had flu shot this year. According to his Country Side Acres his last flu shot was in 2013.

SOCIAL HISTORY: Apparently he is a former smoker. I really do not know. He did not answer that question. No alcohol use to our knowledge.

His CURRENT MEDICATIONS are:

1. Acetaminophen prn.
2. Albuterol nebulizer every two hours prn.
3. Amlodipine 5 mg daily.
4. Doxazosin 2 mg daily at bedtime.
5. Lorazepam 1 mg t.i.d.
6. Milk of Magnesia.
7. Seroquel 50 t.i.d.
8. Valproic Acid. He takes four 125 mg sprinkles in the morning and two of 125 sprinkles in the evening.
9. Zofran prn.

REVIEW OF SYSTEMS: Additional history: He is usually 90% on room air. He is DNR/DNI. He really voices no complaints. He cannot give me any history. But apparently, according to his brother he had been doing very well over the past three days and his nurses at the facility stated he can go days without meds.

ON EXAM: He is lying in the fetal position breathing rather rapidly with a respiratory rate around 26. He is tachycardic on admission; that has slowed down some. His temperature 97.9 on admission, now 99.2. Blood pressure 195/100 on admission. He was 88% on 10 liter nonrebreather when he came in; he is now 92% on 2 liters. Actually when he took off his oxygen mask and had it lying next to him he was satting at 95%. He

HISTORY AND PHYSICAL	PATIENT NAME: PATIENT NO: HOSPITAL NO: PHYSICIAN: D.O.B. DATE:

is very somewhat unkempt. He does not answer any questions. He opens his eyes occasionally. No scleral icterus. He would not open his mouth, but even his mucous membranes are slightly dry. No cervical lymphadenopathy. Lungs reveal inspiratory and expiratory rales, a lot of gurgling. His heart is regular. His abdomen is soft, does complain of some tenderness in the left lower quadrant but very difficult to examine as he would not lie on his back. No peripheral edema. Skin is warm to the touch.

LAB: Potassium 3.3, glucose 147, creatinine 1.32, white count 13.8, hemoglobin 12.1. Blood cultures pending.

ASSESSMENT:
1. 70-year- old gentleman with probably aspiration pneumonia, exacerbation of COPD.
2. Recently intubated at Hospital, possibly aspiration pneumonia given his difficulty swallowing, puts him at a higher risk for more hospital acquired pneumonias. Hence, I will start Zosyn.
3. His history of seizure disorder with recent grand mal seizures resulting in him stopping breathing and requiring intubation. He is a DNR/DNI. No evidence of seizures currently. Missed doses of his medications often but currently on Depakote sprinkles.
4. Hypoxia improved.
5. Seizure disorder.
6. Lewy body dementia with hallucinations but less recently.
7. Hypertension.
8. Prostatic hypertrophy.

PLAN: Admit for IV Zosyn, nebs, IV Solu-Medrol, oxygen support. We will need to restore his potassium and perhaps run a liter of fluid with some potassium in it and hopefully that will restore his potassium, as I do not think he will tolerate IV potassium and he will not take it p.o.

D: 01/22/16 time: 2214
T: 01/23/16 time: 0708

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01/23/16 16:15

	PATIENT NAME: ACCOUNT NO: HOSPITAL NO: PHYSICIAN: D.O.B.
PROGRESS NOTE	ADMIT DATE:

DATE: 01/23/2016

Mr. Giese was admitted yesterday with respiratory distress and right sided pneumonia likely aspiration. He is much better today, refusing his medications. He is receiving IV antibiotics in the form of Zosyn. His white blood cell count did go up a bit today from yesterday, not surprising, was 13.8 yesterday, today 14.5; that may also be a steroid effect. We will continue to follow. He refuses Solu-Medrol, so putting him on prednisone. Need to disguise his medications as he does refuse to take them due to his mental illness. He also has a history of seizure disorder with no active seizures currently. He was hoping to go home today but I do not think it is a safe thing for him to do because he was intubated several weeks ago, not because of pneumonia but because of a seizure and medication. He is a DNR/DNI. T-max yesterday 101.3. Blood cultures are pending. Temperature now 99.3.

ON EXAM he does not appear in any acute distress. He is sitting up in bed with his oxygen on, very cooperative. Yesterday he was in marked distress. His lungs reveal inspiratory and expiratory wheezes and rales. Heart is regular. He did not give me a good respiratory effort.

ASSESSMENT:
1. Probable aspiration pneumonia with respiratory distress and failure, now improved with IV antibiotics and oxygen therapy.
2. Seizure disorder.
3. Lewy body dementia.
4. Noncompliance with meds, refuses them.
5. COPD with exacerbation.

PLAN: Continue with his hospitalization until tomorrow. Hopefully he will be able to go home then. Zosyn will be continued for the aspiration particularly since he was intubated roughly four weeks ago to assure no hospital acquired pneumonia. Continue with his medications. I did add prednisone if he will take it, and if he is doing well tomorrow we can discharge him.

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