# CDI Clinical Scenario 12

**CLINICAL DOCUMENTATION IMPROVEMENT:**

***An Introduction Into The Field of CDI***

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

| | |
|---|---|
| **Discharge Summary/ Transfer to Swing Bed** | **PATIENT NAME:**<br>**PATIENT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.**<br><br>**ADMISSION DATE:** |

DATE:

DATE OF ADMISSION:

DATE OF TRANSFER:

DIAGNOSES:
1. Community-acquired pneumonia
2. Mild systolic congestive heart failure
3. Diarrhea, resolved

HISTORY: Patient presented after a day of diarrhea, fever, cough, seen at a local clinic in Webster. X-ray showed pneumonia. She was transferred over to the emergency room and admitted for treatment.

CURRENT MEDICAL PROBLEMS:
1. Hypertension
2. Macular degeneration
3. Chronic kidney disease stage III
4. Hyperlipidemia

MEDICATIONS on admission:
1. Propranolol LA 120 daily
2. Glucosamine
3. Multivitamins
4. Tylenol
5. Fish oil
6. Aspirin 81 mg

Her initial exam: She is 95% on 2L, blood pressure 115/53, pulse 83, respires 18. Did not appear toxic. Breath sounds decreased bilaterally. Abdomen soft. Chest x-ray shows bilateral lower infiltrates. Her white count was 11.5, hemoglobin 12.4, monocytes 14. Sodium 137, potassium 3.9, BNP 1060, creatinine 1.19. Urine positive, 2+ ketones, protein, negative leukocyte esterase, 6-10 WBCs. EKG showed sinus rhythm.

HOSPITAL COURSE: In the emergency room the patient received a dose of Levaquin IV. She did have a hypoxic episode down to 88 on room air, hence the O2. Patient was admitted and given a dose of IV Lasix because of the failure. She was given IV Levaquin, oxygen, Zofran and Imodium as needed. Influenza swabs were negative. Urine and blood cultures eventually came

| | |
|---|---|
| **Discharge Summary/ Transfer to Swing Bed** | **PATIENT NAME:**<br>**PATIENT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.** 1<br><br>**ADMISSION DATE:** |

back negative. She was given incentive spirometry. Over the next several days she remained afebrile, she was weak. She had some PT/OT working with her, respiratory was working with her. They recommended swing bed for ongoing cares. It was felt that she probably was going to need to have home O2 for a while because she was desatting down into the 70s on room air with activity, that was limiting her activity. No significant pain. She was transferred over to swing bed for ongoing PT/OT.

She will be given oral Levaquin for another three days along with her other medications to include:

1. Aspirin 81
2. Fish oil
3. Garlic oil
4. Glucosamine
5. Multivitamin
6. Ocuvite
7. Primidone
8. Propranolol 120
9. Timolol
10. Albuterol nebs p.r.n.
11. Lovenox will be continued for DVT prophylaxis

D: T:
ELECTRONICALLY SIGNED BY:

| | |
|---|---|
| EMERGENCY ROOM RECORD | PATIENT NAME<br>R<br>PATIENT NO:<br>HOSPITAL NO:<br>PHYSICIAN:<br>D.O.B.<br>DATE: |

DATE:

CHIEF COMPLAINT: Pneumonia.

HISTORY OF PRESENT ILLNESS: Patient is an 89-year-old woman who has been sick for about five days anyway. She had gotten a cold, she started getting chills, harsher cough about five days ago, she is coughing up yellowish, just not feeling well. Her appetite is down. She is eating very little. She is not doing terribly well with liquids and then she started having some diarrhea today. She went into the Ingalls Clinic today and was found to have pneumonia on chest x-ray, it looks like it is in the right upper lobe and maybe a little bit in the right middle lobe. Her white count was normal at 11.7. They did draw a BNP which had not returned at that point, they had not done any other tests, so they sent her over here. When she got here her pulse ox was noted to be 88% on room air. She just generally is not feeling particularly good.

ALLERGIES: PENICILLIN, ESTROGEN, CODEINE

CURRENT MEDICATIONS:
1. Glucosamine chondroitin
2. Multivitamin
3. Ocuvite
4. Primidone
5. Propranolol
6. Timolol eyedrops
7. Tylenol

PAST MEDICAL HISTORY is significant for:
1. Arrhythmias which includes, I believe I saw, paroxysmal supraventricular tachycardia of some sort
2. Hypertension
3. Some degree of renal failure, although having said that her kidney function today is pretty good

REVIEW OF SYSTEMS: She has had the fevers and chills and mentioned. She has not been sleeping because of cough at night, she is coughing up yellowish. No definite URI symptoms. Her mouth does feel dry. She does feel lightheaded at times. She is feeling weak. She has felt nauseated. She has been having increased looser stools. She is urinating less.

PHYSICAL EXAM: Temperature 98.5, pulse 79, respirations 20, blood pressure 177/63. General is a well-developed, well-nourished elderly woman. She has a bit of a quavery voice.

| | |
|---|---|
| **EMERGENCY ROOM RECORD** | **PATIENT NAME:** [illegible]<br>**R**<br>**PATIENT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.:**<br>**DATE:** |

Her color - she is a little pale. Mucous membranes are a little on the dry side. Her lungs were clear, did sound like she had a couple of crackles in the bases, more on the right than the left. Her heart was regular rate. When I saw her she had O2 in place, at 3L she was at 97%. Her abdomen had positive bowel sounds, soft, nontender. Extremities without edema.

LABORATORY STUDIES: CBC from Ingall's Clinic showed a white count of 11.5 with somewhat elevated neutrophils. Her chest x-ray from there showed an infiltrate in the right upper lobe but I do not have an old one to compare with. Her chemistries: Pretty normal sodium at 137, potassium 97, glucose 124, BUN 15, creatinine 1.2. Her albumin is a little low at 2.6, alk phos and SGOT are a little elevated. Troponin is less than 0.04. Her BNP is 1060 which was obtained because of the cough and hypoxia. We also drew a blood culture.

ER COURSE: She was started on Levaquin after blood culture was drawn, 500 mg IV. I spoke with Dr. Jeffrey Eichten about the situation. We will go ahead and get her admitted for O2 therapy, antibiotics, and hydration as she did seem a little on the dehydrated side as she arrived.

EKG showed a normal sinus rhythm without any acute changes.

DIAGNOSES include pneumonia, some dehydration, and nausea.

D: 1
ELECTRONICALLY SIGNED:
SIGNDATE

| | |
|---|---|
| **HISTORY AND PHYSICAL** | **PATIENT NAME**<br>**PATIENT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.**<br>**DATE:** |

DATE:

PRIMARY CARE DOCTOR:

CHIEF COMPLAINT: Ongoing cough

This 89-year-old female presents with ongoing cough over the last five days. She thinks she got an infection from her local card-playing group. Also recently saw a relative who had flu-like symptoms of body aches and diarrhea. Patient has had diarrhea over the last five days without any vomiting, no blood in the stool. She has had a persistent cough every few minutes with sleep disturbance. The cough is better now after being seen in the emergency room. She was seen by Dr. clinic earlier today and received a chest x-ray which had concerning findings, possible pneumonia, was told to come to Spooner emergency room. She did have a CBC at Dr. clinic earlier this morning, reviewed below. Otherwise she denies any severe abdominal pain but she is having some abdominal cramping at times, some back ache. She feels like her breathing is more stable now but she is having frequent cough with yellow phlegm production. Negative for any lower extremity swelling. Subjective fever and chills over the last few days also.

Otherwise, a 10-point review of system was done and negative other than per HPI.

HER PROBLEM LIST includes:

1. History of pulmonary hypertension
2. Severe macular degeneration
3. Paroxysmal supraventricular tachycardia
4. Chronic kidney disease stage III
5. History of vasovagal reaction when she sees blood or gets needle pokes
6. Prediabetes
7. Osteopenia
8. Tension tremor
9. Glaucoma
10. Hyperlipidemia
11. Essential hypertension
12. Numerous sites with severe arthritis

SURGICAL HISTORY:

1. Laser surgery of her left eye for glaucoma
2. Appendectomy
3. Bilateral cataract extraction

| HISTORY AND PHYSICAL | PATIENT NAME:<br>PATIENT NO:<br>HOSPITAL NO:<br>PHYSICIAN:<br>D.O.B.<br>DATE: |
|---|---|

FAMILY HISTORY: Daughter with immunodeficiency disorder.

SOCIAL HISTORY: Four children, married, lives in Webster Wisconsin, she is retired.

ALLERGIES: CALCIUM, CODEINE, PENICILLIN, PREMARIN, DILTIAZEM, PRIMIDONE

CODE STATUS reviewed today, DNR/DNI

OUTPATIENT MEDICATIONS:

1. Propranolol LA 120 mg daily
2. Glucosamine chondroitin supplement
3. Multivitamin
4. Tylenol p.m. as needed for sleep 25 mg
5. Fish oil 1 g daily
6. Aspirin 81 mg daily
7. Timolol ophthalmic drops 0.5% bilateral eyes once daily
8. Ocuvite tablet daily
9. Garlic supplement daily

VITAL SIGNS: BMI 24, weight is 62 kg, 95% on 2 L nasal cannula, 115/53 for blood pressure, temperature afebrile, pulse 83, respirations 18.

She is a nontoxic female. She has mattering of both of her eyes which she states is chronic. Oral mucosa is a bit on the dry side. Nares are clear. Neck is supple. Heart rate is distant, sounds regular, I do not appreciate a murmur. Breath sounds are a bit decreased bilaterally, I do not hear any obvious crackles or rales. She does not look toxic in general. She is awake, alert, oriented. Abdomen is soft, nontender, negative for organomegaly. She has had diarrhea over the last five days. Lower extremity trace edema.

Two-view chest x-ray reviewed per CT from I clinic, I do not have a comparison. It looks like bilateral lower lobe pneumonia. Also some haziness in the upper lobes bilaterally, more impressive on the right side. This could be congestive changes in the upper lobes also. Overall impression per my read is bilateral pneumonia.

LABS from Dr. Ingall's clinic: White count 11.5, hemoglobin 12.4, platelets 346, neutrophil percentage normal at 71, monocytes 14, absolute neutrophils slightly elevated at 8.2. Per Spooner emergency room sodium 137, potassium 3.9, glucose 124, troponin negative x1, ALT 58, B-natriuretic peptide 1060, creatinine 1.19. Urine positive with 2+

| | |
|---|---|
| **HISTORY AND PHYSICAL** | **PATIENT NAME:**<br>**PATIENT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.**<br>**DATE:** |

ketones, positive for 2+ protein, negative nitrite, trace leukocyte esterase, 6-10 white cells. Alk phos a bit elevated at 191, AST is 45.

ECG done in the emergency room shows normal sinus rhythm, rate of 81. No ST elevation, depressions, or Q-waves.

ER COURSE: She received a dose of 500 mg of Levaquin IV. Blood culture was taken and she was given IV fluids. It was noted in the ER she was hypoxic down to 88% on room air.

IMPRESSIONS:

1. Bilateral community-acquired pneumonia consistent with sepsis with left shift on CBC as well as hypoxia in the emergency room
2. Elevated B-natriuretic peptide, likely some congestive failure secondary to the pneumonia
3. Elevated alk phos
4. DNR/DNI
5. History of diarrhea, possibly viral syndrome such as gastroenteritis

PLAN: We will place inpatient, anticipate a 2-midnight stay with telemetry for community-acquired pneumonia. We will check a metabolic panel, CBC with differential, CRP in the morning. I am going to give her a dose of IV Lasix now, I think she is having some congestive failure with the pneumonia. Continue the Levaquin. Recheck her status in the morning. Notably, she had some hypoxia, that is improved with oxygen, she is needing oxygen now. Continue her regular home meds with the addition of IV fluids, the Levaquin, p.r.n. Zofran, Imodium as needed for loose stools. Will perform influenza swab. Albuterol neb as needed, oxygen, and incentive spirometer.

Outpatient she may need further workup with an echocardiogram eventually. Also the elevated alkaline phosphatase could be followed up with a GGT and recheck hepatic labs in the future. Keep her on telemetry, DVT prophylaxis with low-dose Lovenox. Again, I confirmed with the patient she would like to be DNR/DNI.

D: 12/28/2015 1739 T: 12/29/2015 0745
ELECTRONICALLY SIGNED:
12/30/15 09:32

| | |
|---|---|
| **PROGRESS NOTE** | **PATIENT NAME:**<br>**ACCOUNT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.**<br><br>**ADMIT DATE:** |

DATE:

: is doing quite well today. She is eating breakfast. She is feeling weak overall but no coughing or breathing problems, no swelling in her legs, no chest pain. She feels better but just weak. Her medicine list is reviewed, same as admission.

Vital signs: Afebrile, 95% on 1 ½ liters of $O_2$, BP 129/55, respirations 22, pulse 73, nontoxic female up eating breakfast, no apparent distress. Air movement is better in the bases. She does have some fine crackles. Heart: Regular rate and rhythm, 2+ radial pulse, awake, alert and oriented. Trace lower extremity edema.

LABS REVIEWED: Metabolic panel essentially unremarkable. Creatinine continues to be stable at 1.1. Her CRP is greatly elevated at 28, hemoglobin 10, MCV 89. White count is 10.9.

IMPRESSION:

1. Community acquired pneumonia, bacterial with elevated inflammatory markers and hypoxic consistent with sepsis. Blood cultures pending.
2. Mild congestive failure likely with elevated BNP secondary to pneumonia and faint crackles in the bases.

PLAN: Continue current cares. I will have her get one more dose of Lasix tomorrow morning and likely discontinue the fluids at that point also depending on her status. Continue oxygen supportive, IV antibiotics, IV fluids. She is fairly weak today as expected with such a pneumonia. Anticipate needing at least a few more days in the hospital, potential rehab stay. Will have PT/OT likely assess tomorrow.

JE/gm
D: time:
T: time:

ELECTRONICALLY SIGNED BY:

| | |
|---|---|
| | **PATIENT NAME:**<br>**ACCOUNT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.** |
| **PROGRESS NOTE** | **ADMIT DATE:** |

DATE: 12/30/15

Marie is still coughing quite a bit of yellow phlegm. She is receiving IV fluids, IV antibiotics. She is not having any significant pain. She did get some nausea maybe after taking the cough syrup this morning. No other concerns. Her husband is present at interview. She has not really been ambulating. The telemetry is bothering her and she wonders if she can remove it. She is eating and drinking well.

Her medicine list is reviewed:

1. Her home meds with the addition of low-dose IV fluids.
2. Lovenox.
3. Levaquin IV.

Vital signs - afebrile, pulse 66, respirations 20, BP 145/60, 93% on one liter nasal cannula. Awake and alert female, does not appear toxic. Heart is a regular rate and rhythm. On telemetry she is sinus rhythm, rate of 80. Increased breath sounds in the bases with faint crackles. 2+ radial pulse. Lower extremity without edema.

LABS REVIEWED: Her sodium and potassium are normal. CRP down to 23 from 27, creatinine is stable at 1.09. Her bands are elevated a little bit at 7 today compared to yesterday at 4. Her neutrophil percentage is 70%. Her ANC jumped up from 6 to 10. Blood culture negative x two days.

IMPRESSION:

1. Bilateral bacterial pneumonia with sepsis.
2. Weakness secondary to #1.
3. Nausea and cough secondary to #1.

PLAN: We will saline lock her IV; she is drinking well, stop telemetry. It has been two days on telemetry and her heart rate is stable, it is bothering her and we will discontinue that for now. PT/OT evaluation. I am going to stop the Lasix, recheck a CRP, BNP, metabolic panel and a CBC in the morning. Continue current antibiotics. I encouraged spirometry. Respiratory therapy is following also. She is receiving DuoNebs now, started yesterday, and acapella for respiratory toilet. I will see her back in the morning. I had educated her that she does have a severe infection here and she is contemplating eventual Home Care at point of discharge, certainly she needs some more treatments. Also, I asked radiology to review the patient's x-ray from Dr. [redacted] Clinic in case we need a comparison in the near future.

JE/gm
D: 12/30/15 time: 1000
T: 12/30/15 time: 1052

| | |
|---|---|
| **PROGRESS NOTE** | **PATIENT NAME:**<br>**ACCOUNT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.**<br><br>**ADMIT DATE:** |

DATE:

is still coughing quite a bit during the evening. She denies any pain. She is feeling quite weak. She is using a walker for ambulation. Therapy saw her yesterday. She will likely be a great swing bed candidate once she is stable. Her IV infiltrated. We will replace that. She is receiving IV fluids. She is drinking well. Her appetite is low. She denies any pain. She is having a little bit of abdominal bloating. She has a history of recurrent diarrhea throughout her life; it sounds like an IBS type situation. No constipation.

HER MEDICINE LISTS are reviewed, her home meds including propranolol along with IV Levaquin.

SUBJECTIVE: Respiratory Therapy has consulted patient. Home O2 can be qualified for outpatient. Forms were signed today. I had radiology look at the chest x-ray from Dr. clinic yesterday, and Dr. was unable to give official report due to the x-ray being done at a different clinic but did give me an unofficial report that he believes it is a right upper and right middle lobe infiltrate.

EXAM: Vital signs: afebrile, pulse 76-78, respirations 18, blood pressure a little elevated 145/65, 93% on 1 liter nasal cannula. Awake and alert female. Air movements improved again today compared to yesterday, some faint crackles right upper and right middle lobe. Bases sound clear now, no wheezing. Heart: regular rate and rhythm. I do not appreciate a murmur. Abdomen: soft, nontender. Lower extremity without any edema.

LABS: Sodium 138, potassium 3.9, b-natriuretic peptide 952, CRP down to 15 from 23, creatinine 0.99, white count is 14.8, hemoglobin 10, MCV normal at 89, ANC is at 10.8.

IMPRESSION:

1. Community acquired pneumonia with sepsis, slowly improving but still the patient is quite weak. Certainly would be a good swing bed candidate eventually.
2. Abdominal bloating, mild, suspect secondary to being sedentary here in the hospital along with antibiotics.
3. History of pulmonary hypertension, stable.
4. History of supraventricular tachycardia, stable on propranolol.
5. DNR/DNI.

PLAN:

1. We will continue O2 therapy and IV antibiotics. I will sign out the patient to the hospitalist on call over the weekend. Anticipate transition to swing bed at some point once medically stable. Recheck lab work in the morning. Consider repeating an x-ray if her situation declines. She might have a little bit of heart failure here but overall appears

| | |
|---|---|
| PROGRESS NOTE | PATIENT NAME:<br>ACCOUNT NO:<br>HOSPITAL NO:<br>PHYSICIAN:<br>D.O.B.<br><br>ADMIT DATE: |

DATE: 01/01/2016

**SUBJECTIVE**

Interim history since last seen: Pt seen and examined up in the chair. Has been ambulating short distances. Had 2 BMs this am. Reports a poor appetite, however, it is improving. Denies f/ch/n/v. Had stomach cramping last night, drank prune juice before bed as she did not have a "good" BM yesterday. Was able to sleep 4 hours at one time. Denies cp/difficutly breathing. Reports shortness of breath with her nebulizer treatments and with walking. Using her IS independently. Flutter valve with nebs.

**Review of Systems:**

Pertinent items are noted above.

**OBJECTIVE**

Labs and Imaging reviewed.
BP 156/70 mmHg | Pulse 82 | Temp 97.7 | Resp 24 | SpO2 92% on 0.5 L NC

**Lab:**

BMP unremarkable.
CRP 13.54 trending down 14.91/23.67/27.80
CBC - wbc trending upward now 16.3 (14.8/13.0), hgb 11.1, hct 32.1, plts 495

**Imaging:**

No new imaging.

**Exam:**

General - Alert, NAD, sitting up in bed.
Cardiovascular - S1,S2. RRR no m/g/r, no JVD.
Lungs - Decreased bases bilaterally, end expiratory wheezing noted to RLL. No use of accessory muscles.
Skin - No rashes, skin warm and dry, no erythematous areas on exposed areas.
Abdomen - Active bowel sounds. Soft, non-tender, and non-distended. No peritonitis.
Neurological – Alert and oriented x 3, speech clear, face symmetric, PERRL, extraocular movements intact, x4 equal ext strength.

**ASSESSMENT/PLAN**

This is a 89 yo female admitted with CAP, slowly improving. CRP decreasing, wbc increasing. Afebrile. VSS.

| | |
|---|---|
| | **PATIENT NAME:**<br>**ACCOUNT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B** |
| **PROGRESS NOTE** | **ADMIT DATE:** |

Active Problem List
1. Community acquired pneumonia - continues on scheduled and prn nebs, IV levaquin, supplemental oxygen at 0.5 lpm. Using Is and Flutter valve. Will repeat CXR, recheck BNP - was elevated, trending downward.
2. Abdominal distention - improved with prune juice, passing gas, had a small BM this am.
3. Hx of SVT - continues on home Inderal.

Pain Control: Tylenol as needed.
Activity: Up as tolerated, ambulate at least TID. PT/OT
VTE Prophylaxis: Ambulation, Lovenox 30mg SQ Daily.
GI Prophylaxis: None at this time.
Nutrition: 2 gram NA.
Bowel regimen: Will add Miralax prn.
Last BM - 1/1/2016

Disposition planning: Appreciate SS assistance with dispo planning. Pt unsure if she is willing to do a swing bed program at a nursing home. Anticipate she will benefit from a swing bed program.

I have discussed the case with my physician collaborator Dr. [redacted] / who is in agreement with the plan of care. Dr. [redacted] will be notified immediately if any issues arise which are outside my scope of practice.

ELECTRONICALLY SIGNED BY: [redacted]
01/04/16 06:43

| | |
|---|---|
| **PROGRESS NOTE** | **PATIENT NAME:**<br>**ACCOUNT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.**<br><br>**ADMIT DATE:** |

DATE: 01/02/2016

**SUBJECTIVE**

Interim history since last seen: Pt seen and examined up in the chair. She reports she had a large bowel movement today. Did not sleep well last night due to abdominal cramping. She denies f/ch/n/v. Ate a good lunch. Denies cp/difficulty breathing. Has been ambulating in the halls, does report minimal shortness of breath with activity.

**Review of Systems:**

Pertinent items are noted above.

**OBJECTIVE**

Labs and Imaging reviewed.
BP 147/61 mmHg | Pulse 84 | Temp 97.9 | Resp 18 | SpO2 94 % on 0.5.

**Lab:**

BMP - Na 135, K 4.5, cl 96, CO2 32.4, glucose 114, BUN 13, Ca 9.1, creat 0.98
CRP 9.58
CBC - WBC 12.6, hgb 10.8, hct 31.2, plt 486

**Imaging:**

CXR - "IMPRESSION: COPD with bibasilar infiltrates more marked on the right at the base and at the right apex. Suggest comparison studies or short term interval followup to differentiate acute from chronic changes."

**Exam:**

General - Alert, NAD, sitting up in the chair.
Cardiovascular - S1,S2. RRR no m/g/r, no JVD.
Lungs - CTAB, decreased bases. Even, non labored.
Abdomen - Active bowel sounds. Soft, non-tender, and non-distended. No peritonitis.
Neurological – Alert and oriented x 3, speech clear, face symmetric, PERRL, extraocular movements intact, x4 equal ext strength.

**ASSESSMENT/PLAN**

This is a 89 yo female admitted with CAP, slowly improving. CRP decreasing, wbc improving. Afebrile. VSS.

Active Problem List
1. Community acquired pneumonia - continues on scheduled and prn nebs, IV levaquin,

| | |
|---|---|
| **PROGRESS NOTE** | **PATIENT NAME:**<br>**ACCOUNT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.**<br><br>**ADMIT DATE:** |

supplemental oxygen at 0.5 lpm. Using Is and Flutter valve. Slowly improving. Added Prednisone taper. (60/40/20)
2. Abdominal distention - improved, had a BM, no nausea or vomiting. Appetite improving.
3. Hx of SVT - continues on home Inderal.

Pain Control: Tylenol as needed.
Activity: Up as tolerated, ambulate at least TID. PT/OT
VTE Prophylaxis: Ambulation, Lovenox 30mg SQ Daily.
GI Prophylaxis: None at this time.
Nutrition: 2 gram NA.
Bowel regimen: Miralax prn.
Last BM - 1/2/2016

Disposition planning: Appreciate SS assistance with dispo planning. Pt unsure if she is willing to do a swing bed program at a nursing home. Anticipate she will benefit from a swing bed program.

I have discussed the case with my physician collaborator Dr. / who is in agreement with the plan of care. Dr. will be notified immediately if any issues arise which are outside my scope of practice.

ELECTRONICALLY SIGNED BY:
01/04/16 06:43

| | |
|---|---|
| | **PATIENT NAME:**<br>**ACCOUNT NO:**<br>**HOSPITAL NO:**<br>**PHYSICIAN:**<br>**D.O.B.** |
| **PROGRESS NOTE** | **ADMIT DATE:** |

Active Problem List
1. Community acquired pneumonia - continues on scheduled and prn nebs, IV levaquin, supplemental oxygen at 0.5 lpm. Using Is and Flutter valve. Slowly improving. Added Prednisone taper. (60/40/20)
2. Abdominal distention - improved, had a BM, no nausea or vomiting. Appetite improving.
3. Hx of SVT - continues on home Inderal.
4. Insomnia - usually takes Tylenol PM at home, diphenhydramine and Tylenol ordered here.

Pain Control: Tylenol as needed.
Activity: Up as tolerated, ambulate at least TID. PT/OT
VTE Prophylaxis: Ambulation, Lovenox 30mg SQ Daily.
GI Prophylaxis: None at this time.
Nutrition: 2 gram NA.
Bowel regimen: Miralax prn.
Last BM - 1/3/2016

Disposition planning: Appreciate SS assistance with dispo planning. Pt unsure if she is willing to do a swing bed program at a nursing home. Anticipate she will benefit from a swing bed program. Most likely discharge to home tomorrow with home O2, may benefit from home PT/OT.

I have discussed the case with my physician collaborator who is in agreement with the plan of care. Dr. will be notified immediately if any issues arise which are outside my scope of practice.

ELECTRONICALLY SIGNED BY:
01/04/16 06:43