CDI Clinical Scenario 13

CLINICAL DOCUMENTATION IMPROVEMENT:

An Introduction Into The Field of CDI

MARSI

MEDICAL AUDIT RESOURCE SERVICES, INC.

Spooner Health 1280 Chandler Drive Spooner, WI 54801 (715)635-2111 Fax# (715)939-1559 **PROGRESS NOTE**	**PATIENT NAME:** HOTCHKISS KAREN L **ACCOUNT NO:** 467333 **HOSPITAL NO:** 055648 **PHYSICIAN:** Debbra L. Spexet **D.O.B.** 04/09/1949 **ADMIT DATE:** 01/09/17

DATE: January 16, 2017

SUBJECTIVE

Interim history since last seen: Patient stated that she is feeling better today. Per nursing, the patient had a rough night last night with confusion, hallucinations and pulled-out her NG tube. Today the patient is talking and joking with her husband and Hospice RN. She stated that she does not remember last night. The patient stated that yesterday afternoon she passed gas but has not had a BM. She has abdominal discomfort with movement, but denied pain when lying still. The patient continues with dizziness with standing, which upsets her. The patient will have the NG replaced.

Review of Systems:

Pertinent items are noted above.
All other systems reviewed and found to be negative.

OBJECTIVE

Labs and Imaging reviewed.
BP: 183/89 mmHg; Pulse: 97 bpm; Resp: 21 rpm; SpO2: 94 % on 2L

I&O last 24 hours: intake: 1417, output 2143: 2000urine, 125 NG

Lab:

Sodium 133, potassium 3.5

Imaging:

Flat plate Abd: "still obstructed" -- official read pending

Exam:

General - Alert, NAD, lying in bed, well-groomed but appears tired today
Cardiovascular - regular, S1, S2.
Lungs - very decreased, less use of accessory muscles today
Skin - skin warm and dry
Abdomen - rare low-pitched bowel sounds through-out
Extremities - No edema
Neurological – Alert and oriented x 3, speech clear, face symmetric

ASSESSMENT/PLAN

This is a 67 yo female hospice patient admitted on 1/9/2017 with small bowel obstruction/partial small bowel obstruction. She continues to report some abdominal

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pain with movement, but appears fatigued today. The patient is using and tolerating the Morphine PCA more independently. Per comparison of the abdominal x-ray today's to Fridays, the SBO has not resolved. Overnight the patient was confused and pulled-out the NG; it is being replaced as it has helped some. The patient stated she has passed gas and she does have rare bowel sounds now. The patient continues with dizziness with standing, and has a very supportive family.

Active Problem List
1. Small bowel obstruction - NPO (ice chips sparingly for comfort, may have ginger ale and coffee ice chips), IV fluids for hydration, continue NG, consider repeat abdominal x-ray in a couple of days. Continue PCA of morphine intermediate dosing for pain control, may increase to high dosing if pain not controlled, IV antiemetics, trend labs, start bowel regimen when obstruction clears
2. COPD - continue home nebulizers, albuterol neb PRN every 2 hours, continue chronic O2, continue IV methylprednisolone daily
3. Hypokalemia - resolved with IV potassium replacement protocol yesterday (3.5 today); will give 4 potassium bumps to prevent repeat hypokalemia with active NG, serial exams, trending labs
4. GERD - continue pantoprazole IV BID
5. Anxiety - continue IV lorazepam PRN and PRN Morphine

Code Status: DNR/DNI

Pain Control: PCA morphine - intermediate increase if needed.
Activity: Up as tolerated with assistance
VTE Prophylaxis: Patient refused SCD's, continue Lovenox 40mg Daily
GI Prophylaxis: Pantoprazole
Nutrition: NPO, ice chips sparingly
Bowel regimen: None until obstruction cleared
Last BM: PTA

Disposition planning: Home with hospice pending hospitalization

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: DCTNAME
SIGNDAT

Spooner Health 1280 Chandler Drive Spooner, WI 54801 (715)635-2111 Fax# (715)939-1559 **HISTORY AND PHYSICAL**	**PATIENT NAME:** HOTCHKISS KAREN L **PATIENT NO:** 467333 **HOSPITAL NO:** 055648 **PHYSICIAN:** KIMBERLY M. HAND **D.O.B.** 04/09/1949 **AGE:** 67 **DATE:** 01/09/17

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

ELECTRONICALLY SIGNED:
01/11/17 16:22

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

DATE:

Primary Physician:

Primary admitting diagnosis: Small bowel obstruction

Secondary Diagnoses:
Severe COPD, oxygen and steroid dependent, stable
Hypokalemia, resolved
GERD, stable
Anxiety, stable

Discharge Diagnoses: same as above

Admitting Provider

Discharging Provider

Consultants: phone consult with

Procedures/Imaging:
1/9/17 XR Abd: "FINDINGS: There is no free intraperitoneal air. There are multiple air and fluid filled loops of small bowel in the upper mid abdomen which are mildly dilated measuring up to 3.3 cm in diameter. There is a relative paucity of gas within the colon. IMPRESSION: There are findings most suggestive of an early or partial small bowel obstruction."

1/13/17 XR Abd: "FINDINGS: There is moderate gaseous distension of small bowel. The amount of small-bowel gas has decreased somewhat since January 9, 2017. There is no significant large-bowel gas, large-bowel dilation, or abnormal fecal retention. IMPRESSION: Persistent gaseous small-bowel dilatation. Slightly less small-bowel gas than on prior study."

1/13/17 XR Abd: "FINDINGS: Nasogastric tube extends into the proximal stomach. The stomach is nondilated. Gaseous small bowel dilatation is present in the visualized upper abdomen. IMPRESSION: Nasogastric tube tip in the proximal stomach."

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

1/16/17 XR Abd: "FINDINGS: There is increasing small bowel gas and small bowel dilatation when compared with January 13, 2017. A nasogastric tube is in place. There is minimal stool and scattered gas in the colon, without large bowel dilation. IMPRESSION: Slight increase in small bowel gas and small bowel dilatation."

Hospital Summary: is a 67-year-old female who was admitted to the hospital on 1/9/17 with a partial small bowel obstruction. An NG was not placed due to her nose bleeds and the fact that she was passing some gas and no longer having vomiting. She was made NPO and given IV fluids for hydration. Her medications were switched to IV (the ones that we could). She was started on a PCA of morphine for pain because she normally takes large amounts of oral morphine at home. She tolerated this very well and it did help control her pain. She does have known end-stage COPD that is steroid and oxygen dependent and is on hospice, with hospice aware of the hospital admission. On admission, she did have an elevated WBC of 11.7 with left shift so she was started on IV Zosyn 3.375mg every 8 hours. This was continued for a few days until WBC normalized to 7.3 and it was decided to stop the antibiotics. She started feeling better over the first few days. She had been passing gas, but had still not had a bowel movement. She started to have worsening pain, nausea, and vomiting on 1/13/17 and it was decided to place an NG tube at that time. She did have an episode of respiratory distress on 1/13/17 as well, but returned back to baseline. She has had worsening abdominal pain over the last few days and still has not had a bowel movement. Repeat X-ray yesterday showed a worsening obstruction. I had a long conversation with Karen this morning and it was decided to get the opinion of a surgeon at this point to see if anything can be done to help. I spoke with Ann Nelson, NP with Dr. Dettbarn at Sacred Heart Hospital in Eau Claire and they have agreed to take Karen in transfer for a surgical consult for her bowel obstruction. Karen, her husband, Gene, and their son were informed of the plan and she will transfer via ambulance with orders for pain medicine if needed during transport. NG will be clamped during transport and her IV fluids will be continued. During hospitalization she did have hypokalemia which was replaced with our IV potassium replacement protocol. Potassium on day of discharge was 4.0. She was given 1mg IV morphine and 0.5mg IV lorazepam prior to discharge, as well as 4mg IV Zofran.

Discharge Medications:
Hospital medications:
Ondansetron 4mg IV PRNQ4
Acetaminophen 650mg rectal sup PRNQ4

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

Morphine PCA intermediate dosing 1mg every 6 min with hour lockout 10mgDiphenhydramine 25mg IV PRNQ6
Duonebs 3ml QID
Atropine 1% ophthalmic drops 2 drops sublingual PRNQ4 secretions
Albuterol inhaler 2 puffs PRNQ6
Methylprednisolone 16mg IV daily
Lorazepam 0.5mg IV PRNQ4
Pantoprazole 40mg IV BID
Eonxaparin 40mg SQ daily
Promethazine 12.5mg IV PRNQ6
Cepacol lozenges PO PRN
IVF D51/2NS w/ 20 Kcl @ 50ml/hour
Scopolamine 1.5mg patch Q72 hours
Albuterol 2.5mg/3ml nebulizer 2.5mg PRNQ2
Metoprolol tartrate 5mg/5ml 7.5mg IVP Q6 hour

Prior home medications:
Albuterol sulfate 0.083% nebulizer solution, 1 nebulizer every 4 hours PRN
Atropine sulfate 1% solution, 2-4 drops sublingual every 4 hours PRN
Biotene toothpaste PRN
Biotene moisturizing mouth spray PRN
Caffeine 100mg PO PRN
Dextromethorphan Hbr 15mg PO every 4 hours PRN
Eszopiclone 2mg PO at bedtime
Duonebs QID
Clonazepam 0.5mg PO every 4 hours PRN
Lorazepam 2mg/1ml oral solution, 0.5-2mg QID PRN
Lactulose 10gm PO BID PRN
Lidocaine 5% patch daily PRN
Loratadine 10mg PO daily
Morphine sulfate 100mg/5ml, 5-20mg PO every hour PRN
Metoprolol tartrate 25mg PO BID
Morphine sulfate 15mg PO every 2 hours PRN
Morphine sulfate ER 15mg PO every 12 hours
Morphine sulfate ER 30mg PO every 12 hours
Nitroglycerin 0.4mg sublingual PR
Plavix 75mg PO daily
Pantoprazole 40mg PO BID

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

Proventil 0.09mg/ actuation inhalation 2 puffs every 6 hours PRN
Vitamin D3 2000IU PO daily
Zocor 40mg PO daily
Zolpidem 5mg PO bedtime PRN
Prednisone 20mg PO daily

Discharge Instructions:
Transfer to Sacred Heart Hospital, Dr. Dettbarn accepting
NPO
Activity as tolerates, fatigue/SOB to be activity guide
Continue PIV
Continue IV fluids during transport- D51/2NS w/ 20Kcl @ 50ml/hour
Continue cardiac monitor during transport
Clamp NG for transport
During transport, may give hydromorphone 0.1mg IV every 30 min. PRN

Disposition: Patient is being transferred to ambulance, accepting

All of the transfer instructions were discussed with the patient and/or family member who verbalize understanding and all of the questions were addressed at this time.

I have discussed the case with my physician collaborator Dr. who is in agreement with the discharge plan of this patient.

Discharge Time: Greater than 30 minutes.

Please CC:

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

DATE:

Primary Care Physician:
Admitting Provider:

HPI: is a 67-year-old female who presented to the emergency department this afternoon with severe abdominal pain, nausea, and vomiting. She is a hospice patient for end stage COPD and was instructed to come to the emergency department by her hospice nurse. She states that the abdominal pain started last night around 8pm. She also was vomiting almost all night last night. She did have a very small soft bowel movement this morning. She states "it was a tiny drop." Her hospice nurse apparently gave her an enema today with no results. Her last normal bowel movement was "a couple days ago." Denies fever or shaking chills. Denies chest pain. Does have shortness of breath, but no worse than usual for her. She wears 2L oxygen via nasal cannula chronically. She was found to have a small bowel obstruction on x-ray. Hospice was contacted and agreed to an inpatient admission to the hospital for the bowel obstruction denies other concerns at this time. She is not currently having nausea or vomiting.

Past Medical History:
Opioid agreement 1/15/2016
Esophageal reflux
Chronic bronchitis/emphysema
Severe COPD
Anxiety
Hyperlipidemia
Abnormal glucose
Myalgia and myositis
Chronic low back pain
Gastroparesis
Chronic constipation
Hyponatremia
Lumbar stenosis/facet arthropathy
Costochondral chest pain

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

Past Surgical History:
Hysterectomy
Mesenteric artery stenting
Bladder sling
Lung resection

Medications:
Albuterol sulfate 0.083% nebulizer solution, 1 nebulizer every 4 hours PRN
Atropine sulfate 1% solution, 2-4 drops sublingual every 4 hours PRN
Biotene toothpaste PRN
Biotene moisturizing mouth spray PRN
Caffeine 100mg PO PRN
Dextromethorphan Hbr 15mg PO every 4 hours PRN
Eszopiclone 2mg PO at bedtime
Duonebs QID
Clonazepam 0.5mg PO every 4 hours PRN
Lorazepam 2mg/1ml oral solution, 0.5-2mg QID PRN
Lactulose 10gm PO BID PRN
Lidocaine 5% patch daily PRN
Loratadine 10mg PO daily
Morphine sulfate 100mg/5ml, 5-20mg PO every hour PRN
Metoprolol tartrate 25mg PO BID
Morphine sulfate 15mg PO every 2 hours PRN
Morphine sulfate ER 15mg PO every 12 hours
Morphine sulfate ER 30mg PO every 12 hours
Nitroglycerin 0.4mg sublingual PR
Plavix 75mg PO daily
Pantoprazole 40mg PO BID
Proventil 0.09mg/ actuation inhalation 2 puffs every 6 hours PRN
Vitamin D3 2000IU PO daily
Zocor 40mg PO daily
Zolpidem 5mg PO bedtime PRN
Prednisone 20mg PO daily

Allergies:
Codeine, gabapentin, Lyrica

Family History:
Noncontributory.

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

Social History:
Lives with husband in Hertel. Denies alcohol use, cigarette/tobacco or street drug use. Currently receiving hospice care.

ROS:
Pertinent items are noted above.
All other systems reviewed and found to be negative.

Physical Exam:
Vital Signs:
BP: 128/81mmHg; Pulse: 113bpm; Temp: 98.5 F°; Resp: 20rpm; SpO2: 94% on 2L
Wt: 70 lbs.

Labs:
Labs reviewed,
CBC: WBC 11.7 with 83% neutrophils, Hgb 13.6, Plt 252
CMP: K+ 3.4, Cl 90, glucose 126, Ca 10.3, crt 0.74
Urinalysis: specific gravity 1.015, negative nitrite and leukocyte, 0-5 WBC, trace bacteria- no culture indicated

Study Results:
1/9/17 XR Abd: "FINDINGS: There is no free intraperitoneal air. There are multiple air and fluid filled loops of small bowel in the upper mid abdomen which are mildly dilated measuring up to 3.3 cm in diameter. There is a relative paucity of gas within the colon. IMPRESSION: There are findings most suggestive of an early or partial small bowel obstruction."

Physical Examination:
General: Pleasant 67-year-old female who appears to be in pain
Head: Normocephalic, atraumatic
ENT: ENT exam normal, PERRLA, EOM intact, mouth and throat mucosa dry and intact with no lesions
Neck: Neck supple, no adenopathy, no JVD
Heart: Regular rate and rhythm. Normal S1, S2.
Pulmonary: Chest symmetric, lungs diminished throughout, no crackles or wheezes noted

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

Abdominal: Hypoactive bowel sounds, abdomen distended, tender to palpation throughout
Skin: Normal skin color, texture, and turgor. No rashes or lesions
Extremities: extremities cool to touch, edema lower extremities negative
Neurologic: Alert and oriented times 3; mental status normal; cranial nerves II-XII normal; muscle strength 5/5, and symmetric

[redacted]
This is a 67 yo female admitted with small bowel obstruction. She has had severe abdominal pain, nausea, and vomiting since last evening. She is a hospice patient, and they have agreed to this inpatient admission to manage the bowel obstruction. She does have an elevated WBC with left shift.

Active Problem List
1. Small bowel obstruction - admit inpatient, NPO, IV fluids for hydration, no NG at this time, if has significant nausea or vomiting, can consider NG, start antibiotics for elevated WBC with left shift (Zosyn 3.375mg every 8 hours), hold oral meds, switch what I can to IV (metoprolol, pantoprazole, lorazepam, etc), start PCA of morphine intermediate dosing for pain control, can increase to high dosing if pain not controlled, IV antiemetics, recheck labs in AM, start bowel regimen when obstruction clears
2. COPD - continue home nebulizers, albuterol inhaler PRN, continue chronic O2, hold oral prednisone and give IV methylprednisolone daily
3. GERD - change pantoprazole to IV dosing BID
4. Anxiety - change lorazepam to IV dosing PRN

Code Status: DNR/DNI

Pain Control: PCA morphine
Activity: Up as tolerated with assistance
VTE Prophylaxis: Patient refused SCD's, so start Lovenox 40mg Daily
GI Prophylaxis: Pantoprazole per home dosing
Nutrition: NPO
Bowel regimen: None until obstruction cleared
Last BM: PTA

Disposition planning: Home with hospice pending hopitalization

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

DATE: 01/10/2017

[redacted]

Interim history since last seen: Pt seen and examined, resting in bed. Reports feeling less bloated today compared to yesterday. Denies passing any flatus, has had increased burping. Reports pain roughly 5-7/10 located to her abdomen. Pain is difficult to describe. I is sleepy/lethargic this morning. Weak, slow to answer. Has had nausea and small amount of emesis. No BM. Using her PCA with encouragement. Trying to avoid NGT, has hx of nose bleeds.

Review of Systems:
Pertinent items are noted above.
All other systems reviewed and found to be negative.

[redacted]

Labs and Imaging reviewed.
BP: 168/80 mmHg; Pulse: 117 bpm; Temp: 99.5 F°; Resp: 16 rpm; SpO2: 88% on 2 L NC.

I&O last 24 hours: 1115/525

Lab:
CBC with improving white count down to 4,800 from 11,700, with decreased neutrophils 79.1% form 83.0 % and 9.1% lymphocytes improving from 6.0%.
Chemistries - Na 134, K 3.6, Cl 94, CO2 36.9, glucose 121, BUN 12, creat 0.61

Imaging:
1/9/2017 2 view abdomen XR - "IMPRESSION: There are findings most suggestive of an early or partial small bowel obstruction."

Exam:
General - Lethargic, cachectic appearing.
Cardiovascular - S1, S2. RRR no m/g/r
Lungs - Coarse crackles throughout lung fields. No use of accessory muscles.
Skin - Scattered areas of bruising in various stages of healing to the dorsal aspect of her hands.
Abdomen - Rare bowel sounds. Soft, tender to LLQ and lower middle abdomen. Slightly distended without peritoneal signs.

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

Neurological – Lethargic awakes easily to voice. Speech clear but soft spoken, face symmetric, PERRL, extraocular movements intact, x4 equal ext strength however generally weak.

ASSESSMENT/PLAN

This is a 67 yo female hospice patient admitted on 1/9/2017 with small bowel obstruction. She continues to report abdominal pain, although tolerable with a Morphine PCA. No flatus/BM, has had increased nausea and burping.

Active Problem List
1. Small bowel obstruction - NPO (ice chips sparingly for comfort), IV fluids for hydration, no NG at this time, if has significant nausea or vomiting, can consider NGT (has hx of nosebleeds), continue IV Zosyn with the improved white count and shift, Continue PCA of morphine intermediate dosing for pain control, can increase to high dosing if pain not controlled, IV antiemetics, recheck labs in AM, start bowel regimen when obstruction clears

2. COPD - continue home nebulizers, albuterol inhaler PRN, continue chronic O2, hold oral prednisone and continue IV methylprednisolone daily

3. GERD - continue pantoprazole IV BID

4. Anxiety - continue IV lorazepam PRN

Code Status: DNR/DNI

Pain Control: PCA morphine - intermediate increase if needed.
Activity: Up as tolerated with assistance
VTE Prophylaxis: Patient refused SCD's, continue Lovenox 40mg Daily
GI Prophylaxis: Pantoprazole
Nutrition: NPO, ice chips sparingly
Bowel regimen: None until obstruction cleared
Last BM: PTA

Disposition planning: Home with hospice pending hospitalization

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.

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

DATE: 1/11/2017

SUBJECTIVE

Interim history since last seen: Resting in bed. Continues to report nausea, vomiting, and abdominal pain. Has not been ambulating in the halls, has been up to the bathroom. Reports good pain control. Denies concerns with voiding. Denies passing flatus, denies any BM. Has increased burping.

Review of Systems:
Pertinent items are noted above.
All other systems reviewed and found to be negative.

OBJECTIVE

Labs and Imaging reviewed.
BP: 146/72 mmHg; Pulse: 107 bpm; Temp: 98.1 F°; Resp: 22 rpm; SpO2: 92% on 2 L NC.

I&O last 24 hours: 555/1726

Lab:
CBC - white count 6.3, hgb 11.1, hct 33.9, ,plt 178 with 80.3% neutrophils, 7.3% lymphocytes
Chemistries - Na 130, K 3.0, Cl 94, CO2 33.3, glucose 107, creat 0.51

Imaging:
No new imaging.

Exam:
General - Lethargic although more awake compared to yesterday, cachectic appearing.
Cardiovascular - S1, S2. RRR no m/g/r
Lungs - Coarse crackles throughout lung fields. No use of accessory muscles.
Skin - Scattered areas of bruising in various stages of healing to the dorsal aspect of her hands.
Abdomen - Rare bowel sounds. Soft, tender to LLQ and lower middle abdomen. Slightly distended without peritoneal signs
Neurological – Lethargic awakes easily to voice. Speech clear but soft spoken, face symmetric, PERRL, extraocular movements intact, x4 equal ext strength however generally weak.

ASSESSMENT/PLAN

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

This is a 67 yo female hospice patient admitted on 1/9/2017 with small bowel Obstruction/partial small bowel obstruction. She continues to report abdominal pain, although tolerable with a Morphine PCA. No flatus/BM, has had increased nausea and burping and emesis today.

Active Problem List
1. Small bowel obstruction - NPO (ice chips sparingly for comfort), IV fluids for hydration, no NG at this time, if has significant nausea or vomiting, can consider NGT (has hx of nosebleeds and pt afraid of not being able to breathe through her nose with her COPD), continue IV Zosyn with the improved white count and shift,
Continue PCA of morphine intermediate dosing for pain control, can increase to high dosing if pain not controlled, IV antiemetics, trend labs, start bowel regimen when obstruction clears

2. COPD - continue home nebulizers, albuterol inhaler PRN, continue chronic O2, hold oral prednisone and continue IV methylprednisolone daily

3. GERD - continue pantoprazole IV BID

4. Anxiety - continue IV lorazepam PRN

Code Status: DNR/DNI

Pain Control: PCA morphine - intermediate increase if needed.
Activity: Up as tolerated with assistance
VTE Prophylaxis: Patient refused SCD's, continue Lovenox 40mg Daily
GI Prophylaxis: Pantoprazole
Nutrition: NPO, ice chips sparingly
Bowel regimen: None until obstruction cleared
Last BM: PTA

Disposition planning: Home with hospice pending hospitalization

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:
SIGNDATE

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

DATE: 1/12/2017

SUBJECTIVE

Interim history since last seen: Pt seen and examined in bed. She denies any emesis in the last 24 hours. Continues to report nausea. Passed a small amount flatus, no BM. Denies fever, chills. Denies chest pain, shortness of breath, difficulty breathing. Reports abdominal pain is the same. Feels like her abdomen is "less hard."

Review of Systems:
Pertinent items are noted above.
All other systems reviewed and found to be negative.

OBJECTIVE

Labs and Imaging reviewed.
BP: 163/94 mmHg; Pulse: 116 bpm; Temp: 98.3 F°; Resp: 20 rpm; SpO2: 95% on RA.

I&O last 24 hours: 3266/514

Lab:
CBC unchanged.
Chemistries - Na 134, K 2.9, cl 96, CO231.2, Cl 108, BUN 6, creat 0.44

Imaging:
No new imaging.

Exam:
General - Alert, less lethargic. Cachectic appearing.
Cardiovascular - S1, S2. RRR no m/g/r
Lungs - Coarse crackles throughout lung fields. No use of accessory muscles.
Skin - Scattered areas of bruising in various stages of healing to the dorsal aspect of her hands.
Abdomen - Rare bowel sounds. Soft, less tender than yesterday. Slightly distended without peritoneal signs
Neurological – Lethargic awakes easily to voice. Speech clear but soft spoken, face symmetric, PERRL, extraocular movements intact, x4 equal ext strength however generally weak.

ASSESSMENT/PLAN

This is a 67 yo female hospice patient admitted on 1/9/2017 with small bowel obstruction/partial small bowel obstruction. She continues to report abdominal pain,

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

although tolerable with a Morphine PCA. Passed amount of flatus. No BM. Nausea remains unchanged. No emesis in last 24 hours.

Active Problem List
1. Small bowel obstruction - NPO (ice chips sparingly for comfort, may have coffee ice chips), IV fluids for hydration, no NG at this time, if has significant nausea or vomiting, can consider NGT (has hx of nosebleeds and pt afraid of not being able to breathe through her nose with her COPD), dc Zosyn with the improved white count and shift, Continue PCA of morphine intermediate dosing for pain control, can increase to high dosing if pain not controlled, IV antiemetics, trend labs, start bowel regimen when obstruction clears

2. COPD - continue home nebulizers, albuterol inhaler PRN, continue chronic O2, hold oral prednisone and continue IV methylprednisolone daily

3. GERD - continue pantoprazole IV BID

4. Anxiety - continue IV lorazepam PRN

Code Status: DNR/DNI
Pain Control: PCA morphine - intermediate increase if needed.
Activity: Up as tolerated with assistance
VTE Prophylaxis: Patient refused SCD's, continue Lovenox 40mg Daily
GI Prophylaxis: Pantoprazole
Nutrition: NPO, ice chips sparingly
Bowel regimen: None until obstruction cleared
Last BM: PTA

Disposition planning: Home with hospice pending hospitalization

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:
SIGNDATE

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

DATE:

Rapid response called to patient room, patient in respiratory distress with rapid respirations and heart rate with decreased responsiveness. Family was called, IV Ativan was already given and IV morphine ordered and given. New orders for 2mg IV morphine every 15 minutes to ease respirations ordered. Nursing will apply a scopolamine patch as the patient has a rattling with breathing. Family arrived and are at bedside. Support given by staff and patient's family MD notified by nursing.

ELECTRONICALLY SIGNED BY:

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

DATE: 1/13/17

Patient is a 67-year-old female who I was requested to come see due to a decline in status. The patient has been admitted to She is currently a hospice patient due to advanced COPD and she has been admitted for small bowel obstruction. Over the last few days they have been doing just bowel rest because they are wanting to avoid additional instrumentation from a nasogastric tube. They had entertained other options at this point and have been continuing with n.p.o. status, IV fluids for hydration. She was on Zosyn for a brief period of time due to a white count shift which has been gone. She has been on Morphine PCA for pain control and continues on her home COPD treatment of nebulizers, O2 and oral prednisone. They have also been adding on some IV Methylprednisolone as well. Today though her status has declined quite a bit. She was in more respiratory distress and more rapid respirations and decreased responsiveness. The family was called. IV Ativan was given. Additional Morphine was given for comfort. Upon my arrival the patient is sleeping comfortably. She does arouse with loud verbal stimuli and does recognize me but she has a very soft spoken voice and still has some abdominal pain that she relates and feels very tired and weak. She relates no other issues at this point. I did discuss with family as well and they were concerned about additional clinical course and treatment for the small bowel obstruction given her underlying COPD as well.

PHYSICAL EXAM: Vital signs noted in CPSI. In general, the patient is alert with loud verbal stimuli but other than that is fairly somnolent. HEENT: Normocephalic, atraumatic. Cardiovascular regular rate and rhythm with significantly diminished air movement bilaterally. Abdomen is a little distended, a little tender to palpation as well. No masses palpated.

LAB VALUES: White count is 9.1 today, hemoglobin stable at 12.7, sodium 133, potassium 3.3, chloride 95, bicarb 30.4, glucose 113, BUN 8, calcium 9.1, creatinine .41.

ASSESSMENT: Small bowel obstruction.
2. End stage COPD.

PLAN: I did recommend repeating plain film abdominal x-ray today to reassess. I do feel it would be appropriate to have an NG tube dropped depending on the status of her obstruction if patient and family want to do continued interventions and it does sound like this is the direction that they still want to start proceeding with. Family does feel that there is still some fight in her and do not want to simply do pure comfort measures at this point despite her being on hospice and we will proceed with a flat plain abdominal film at this point in time and continue with some fluid and potassium replacement.

D: 1/13/17 1202 HOURS

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

DATE:

[redacted]

Interim history since last seen: Patient is awake and stated is feeling the same as always, not good. She continues with abdominal pain but with movement now and not all the time. She stated that it feels like her stomach muscles are sore. She continues with back pain as well but is not having difficulty breathing with the NG tube in place. She denied nausea or urge to vomit around the NG tube. The patient's voice is stronger and she is joking with her husband. She is appropriately using the PCA and feels it is helpful.

Review of Systems:
Pertinent items are noted above.
All other systems reviewed and found to be negative.

[redacted]

Labs and Imaging reviewed.
BP: 166/93 mmHg; Pulse: 109 bpm; Temp: 98.8F°; Resp: 16 rpm; SpO2: 97% on 2L (for patient's comfort due to increased anxiety)
Wt: not done

I&O last 24 hours: Intake: 1963
Output: urine 250ml +1 incontinent
NG 225ml

Lab:
Sodium 137, potassium 3.3, chl 98, BUN 6, crt 0.49

Imaging:
None today

Exam:
General - Alert, NAD, lying in bed, well-groomed
Cardiovascular - S1, S2, RRR
Lungs - fine crackles and wheezes in bases; decreased; uses accessory muscle
Skin - skin warm and dry
Abdomen - absent bowel sounds. Softer, scaphoid, slightly-tender, with some distension.
Extremities - No edema

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

Neurological – Alert and oriented x 3, speech clear, weak

ASSESSMENT/PLAN

This is a 67 yo female hospice patient admitted on 1/9/2017 with small bowel obstruction/partial small bowel obstruction. She continues to report abdominal pain, although tolerable with a Morphine PCA. Per abdominal x-ray yesterday, the SBO has progressed and patient agreed to NG tube placement. Today she stated feeling the same but decreased abdominal pain at rest and no nausea.

Active Problem List
1. Small bowel obstruction - NPO (ice chips sparingly for comfort, may have coffee ice chips), IV fluids for hydration, continue NG, consider repeat abdominal x-ray tomorrow or Monday. Continue PCA of morphine intermediate dosing for pain control, may increase to high dosing if pain not controlled, IV antiemetics, trend labs, start bowel regimen when obstruction clears
2. COPD - continue home nebulizers, albuterol neb PRN every 2 hours, continue chronic O2, continue IV methylprednisolone daily
3. GERD - continue pantoprazole IV BID
4. Anxiety - continue IV lorazepam PRN

Code Status: DNR/DNI

Pain Control: PCA morphine - intermediate increase if needed.
Activity: Up as tolerated with assistance
VTE Prophylaxis: Patient refused SCD's, continue Lovenox 40mg Daily
GI Prophylaxis: Pantoprazole
Nutrition: NPO, ice chips sparingly
Bowel regimen: None until obstruction cleared
Last BM: PTA

Disposition planning: Home with hospice pending hospitalization

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: DCTNAME
SIGNDATE

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

DATE: January 15, 2017

SUBJECTIVE

Interim history since last seen: Awake and stated she feels awful. The patient is having increased chronic back pain; encouraged by nursing to use her PCA more as she is not using it often. Reports dizziness when getting up to the BSC to void. Is not passing gas, but is quite hopeful her bowels will begin to work soon; looking forward to the repeat x-ray tomorrow. Family very supportive.

Review of Systems:
Pertinent items are noted above.
All other systems reviewed and found to be negative.

OBJECTIVE

Labs and Imaging reviewed.
BP: 172/90 mmHg; Pulse: 106 bpm; Temp: 98.1F°; Resp: 20 rpm; SpO2: 95% on 1L
Wt: not done today

I&O last 24 hours: intake: 1417
Output: 2000 urine
NG: 125

Lab:
Sodium 137, potassium 2.8, glucose 92, BUN 6, crt 0.45

Imaging:
None today

Exam:
General - Alert, NAD, lying in bed, well-groomed
Cardiovascular - regular, S1, S2.
Lungs - crackles bases and decreased, less use of accessory muscles today
Skin - skin warm and dry
Abdomen - high-pitched bowel sound left lower quad only
Extremities - No edema
Neurological – Alert and oriented x 3, speech clear, face symmetric

ASSESSMENT/PLAN

This is a 67 yo female hospice patient admitted on 1/9/2017 with small bowel

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

obstruction/partial small bowel obstruction. She continues to report some abdominal pain but more back pain today; she is tolerating the Morphine PCA when she uses it. Per abdominal x-ray on Friday, the SBO has progressed and patient agreed to NG tube placement. The patient stated feeling the same but decreased abdominal pain at rest and no nausea, just dizziness with standing.

Active Problem List
1. Small bowel obstruction - NPO (ice chips sparingly for comfort, may have ginger ale and coffee ice chips), IV fluids for hydration, continue NG, consider repeat abdominal x-ray tomorrow. Continue PCA of morphine intermediate dosing for pain control, may increase to high dosing if pain not controlled, IV antiemetics, trend labs, start bowel regimen when obstruction clears
2. COPD - continue home nebulizers, albuterol neb PRN every 2 hours, continue chronic O2, continue IV methylprednisolone daily
3. Hypokalemia - IV potassium replacement protocol, serial exams, trending labs
4. GERD - continue pantoprazole IV BID
5. Anxiety - continue IV lorazepam PRN

Code Status: DNR/DNI

Pain Control: PCA morphine - intermediate increase if needed.
Activity: Up as tolerated with assistance
VTE Prophylaxis: Patient refused SCD's, continue Lovenox 40mg Daily
GI Prophylaxis: Pantoprazole
Nutrition: NPO, ice chips sparingly
Bowel regimen: None until obstruction cleared
Last BM: PTA

Disposition planning: Home with hospice pending hospitalization

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: DCTNAME
SIGNDATE

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

DATE:

This patient came into our facility. She is on hospice care for end stage chronic obstructive pulmonary disease, wasting disease as well as inability to eat, nausea, very poor appetite. Evaluation of the patient revealed her to be alert and oriented. Her main complaint was, "I can't have a bowel movement, I am not passing gas and I feel nauseous."

Her history is rather protracted. She has been in and out of our facility on numerous occasions with failure to thrive and chronic obstructive pulmonary disease. She had been transferred down to for abdominal pain and they failed to see the necessity of any type of procedure. That she was at such high risk that nothing operative would be done and with her end stage pulmonary disease she is not a candidate for any surgical procedure.

PAST MEDICAL HISTORY/SOCIAL HISTORY, MEDICATION LIST should be reviewed in the nurses' notes.

ON EXAMINATION: She is a cachectic appearing female curled up in a ball. Temperature was 97.7, pulse 116 and regular, respiratory rate 28 and not labored, O_2 sats of 90% on 2 liters, blood pressure 156/78. Head, eyes, ears, nose, mouth and throat showed a cachectic appearing lady, very little in the way of muscle mass. Her arms are dwindled down to sagging skin and bone. She appears slightly dehydrated with mucous membranes that were clearly dry. Lungs were with distant breath sounds, I could hardly hear any inspiratory effort. There is a slight wheeze on expiration. Heart: Regular sinus rhythm, slightly tachycardic at 110-116. Abdomen was mildly protuberant, tympanitic to percussion, active bowel sounds were present. She was tender diffusely, but she was not rigid. Extremities showed distal pulses present, no peripheral edema.

Blood studies include the following: White count of 11,700 with a pretty good shift of 83 neutrophils and only 6 lymphs. Urinalysis - spec grav of 1.015, pH greater than 9, chem 16 revealed slightly low potassium at 3.4, calcium mildly elevated at 10.3, albumin surprisingly normal at 4.1. Flat and upright of the abdomen revealed no gas that I can see in the colon, air fluid levels in the small bowel with some dilated bowel with valvular conniventes. This is all indicative of an early small bowel obstruction and with her symptoms and signs and that she has not been able to have a bowel movement and not passed any flatus and is nauseous correlates with that.

We did have a discussion with the hospice care and they concurred that placing her in the hospital for comfort would certainly be reasonable. We did discuss the case with , our hospitalist and she agreed to take the patient for comfort care and dehydration. The patient was admitted for IV fluids and pain and nausea control.