Alena Rakhman
LTC Rotation 3 H&P 2

Overall much better and more complete. Really good job of organizing a complicated history and presenting it in a coherent way. Biggest things to work on – more detail on the areas of active interest (e.g. ulcer, LE's etc.) and need assessment in the assessment section. How is she – this is where your clinical judgement is reflected and where progress/unaddressed issues are noted.

Identifying Data
Full name: W.K.
DOB: 01/20/1946
Date & time: April 2, 2019 1:00 PM
Location: Gouverneur Skilled Nursing Facility
Religion: Roman Catholic
Marital status: Single
Source of information: Self/medical records
Source of referral: Reliable patient

CC: L hip fx s/p fall x1 month

HPI: 73 y/o F, current smoker w/ 27 pack-year hx, w/ PMHx of RA and HLD admitted to Gouverneur Skilled Nursing facility on 4/2/19 from Mount Sinai Beth Israel Hospital where pt was admitted on 3/4/19 for L hip fx s/p fall. Pt states that she was walking to the bathroom when she slipped and fell down landing on her L side and was unable to get up. As mentioned, could use a little more detail about how she fell and what she landed on (surface and body parts) Denies hitting head of LOC. Pt's coworkers noticed that she did not show up for work for 2 days and called EMS. Upon arrival, EMS noticed pt's LLE externally rotated. Upon arrival to the ED, pt was found to have L femoral neck fx, extended-spectrum beta-lactamases E. Coli sepsis, AKI, hypernatremia, DVT b/l, PE, stage 4 sacral ulcer (presumably a new ulcer, but would be good to establish that it did not precede the fall), deep tissue injuries to LE b/l and perianal fistulas. Pt was started on heparin drip for tx of PE and DVTs, and IVC filter was placed on 3/6/19. On 3/7/19, PICC line was placed on RUE and pt underwent L hip hemiarthroplasty, which she tolerated well. Hypernatremia and AKI was managed w/ IVF and ceftriaxone 2 g w/ improvement. Additionally, pt was found to be in extended-spectrum beta-lactamases E. Coli sepsis and had actinomyces bacteremia, which was likely from the stage 4 sacral ulcer, and she was started on Vancomycin for tx, transitioned to Meropenem of which she completed a 2-week course. Pt will also require additional tx w/ Augmentin 1000 mg Q12H until 9/27/19. On 3/17/19 surgery was consulted and pt underwent extensive debridement of sacral ulcer down to muscle and fascia, which helped to improve pt's leukocytosis. Surgery also proposed diverting ostomy to allow perianal fistulas to heal, but pt declined. Wound staples were removed on 3/22/19 w/ hip improvement. Additional I/D of stage 4 sacral ulcer occurred on 4/1/19, performed by surgery w/ wound care recommendations and clearing pt for d/c. Heparin drip was stopped since no other procedures were planned and pt was transitioned to direct-acting oral anticoagulants. Pt was deemed stable for d/c for sub-acute rehabilitation and is scheduled to f/u w/ PCP, rheumatology, ortho, ID, heme, and pulmonology. Prior to fall and hospitalization, pt was independent and did not have home health aide assistance. Pt used a cane to assist herself w/ ambulation. Pt lives alone on the second floor, w/ 20 steps total. Pt admits to limited community support where she lives. She currently works as an usher at the Gershwin Theatre in Manhattan. Pt is here for skilled rehab services, which requires extensive assist w/ ADLs and wound care. Long-term goal is for pt to be discharged to the community w/ appropriate support. Denies fever, chills, SOB, CP, wheezing, change in appetite, visual disturbance, N/V/D or recent travel.
Overall very well organized and good level of detail except for the details listed above. As we discussed, it might be good to know at the very beginning that she was employed and ambulatory before beginning the rest of the story, but that is possibly a preference of mine rather than a rule.

ADVANCE DIRECTIVE – DNR/DNI

PMHx/PSHx
- RA
- HLD
- Appendectomy (1963) – no complications
- Tonsillectomy (pt unable to recall date) – no complications

Childhood illnesses
- Pt unable to recall

Immunizations

- Influenza – states it was given in 2019, unable to recall exact date
- Pneumovax – states that it was given within 5 years, unable to recall exact date
- PPD – administered on 4/2/19 to R forearm

Medications

- Augmentin 875-125 mg PO Q12H for actinomyces bacteremia (last dose on 9/27/19)
- Oxycodone 10 mg ER Q12H for pain
- Oxycodone 10 mg IR Q4H PRN and 30 min before wound care for pain
- Eliquis 5mg PO Q12H for 3 months for DVT
- Atorvastatin 40 mg PO QHS for HLD
- Senna 17.2 mg PO QD for constipation
- MiraLax 17 g PO QD for constipation
- Bisacodyl 10 mg suppository rectally QD PRN for constipation
- Fleet enema 1 application rectally QD PRN for constipation
- Multivitamin 1 tab PO QD for 3 months for vitamin supplementation
- Vitamin C 500 mg PO QD for supplementation
- Risa-Bid 1tab PO TID for C. Diff ppx
- Enbrel syringe 50 mg/mL (0.98 mL) 50 mg IM weekly for RA
- Miconazole 2% cream apply to groin and buttocks BID for 15 days for rash
  Why PICC line?

Allergies

- NKDA
- No environmental or food allergies

Family History

- Mother → died from natural causes, 86
- Father → died from natural causes, 79
- Grandfather (maternal) → pt doesn't know
- Grandmother (maternal) → pt doesn't know
- Grandfather (paternal) → pt doesn't know
- Grandmother (paternal) → pt doesn't know

Social History

- Pt is a single female, never been married, lives alone on the second-floor walkup with 10 steps per flight, 20 steps total. She does not have a HHA and uses a cane to assist herself w/ ambulation. Pt's emergency contact is her cousin.
- Occupation – currently works as an usher at the Gershwin Theatre in Manhattan. (I later realized I've been to this theater – it's a new one and has elevators and escalators so perhaps she could return after all)
- Habits – current smoker w/ 27 pack-year hx, denies hx of drug or alcohol abuse.
- Education – College.
- Diet – regular diet.
- Exercise – walks in the park 2x/week.
- Safety measures – admits to wearing a seatbelt.
- Sexual hx – denies current sexual activity of hx of STIs.

ROS

General

- denies recent weight loss or gain, loss of appetite, generalized weakness/fatigue, fever or chills, or night sweats

Skin, hair and nails

- denies change in texture, excessive dryness or sweating, discolorations, pigmentations, moles/rashes, pruritus, or changes in hair distribution Need some mention of significant skin pathology – can just refer back to HPI

Head

- denies HA, vertigo, or head trauma

Eyes

- **uses reading glasses;** denies visual disturbance, lacrimation, photophobia, pruritus, or contact use

Ears
- denies deafness, pain, discharge, tinnitus, or use of hearing aids

Nose/Sinuses
- denies congestion, rhinorrhea, epistaxis or obstruction

Mouth and throat
- **wears upper dentures**, denies bleeding gums, sore tongue, sore throat, mouth ulcers, or voice changes

Neck
- denies localized swelling/lumps, or stiffness/decreased range of motion

Breast
- denies lumps or pain

Pulmonary System
- denies SOB, DOE, orthopnea, cough, wheezing, hemoptysis, cyanosis, or PND

Cardiovascular System
- denies CP, palpitations, HTN, irregular heartbeat, edema/swelling of ankles or feet, syncope or known heart murmur

Gastrointestinal System
- denies change in appetite, intolerance to specific foods, nausea, vomiting, dysphagia, pyrosis, flatulence, eructations, abdominal pain, abdominal distention constipation, diarrhea, change in bowel habit, hemorrhoids, or melena At least refer back to HPI for fistulas. Here might want to explore constipation and diarrhea a bit more since either would complicate her hospital course.

Genitourinary System
- denies urinary urgency, urinary frequency, flank pain, nocturia, oliguria, polyuria, dysuria, incontinence, or awakening at night to urinate Need mention of catheter here

Nervous System
- denies HA, seizures, loss of consciousness, sensory disturbances, ataxia, loss of strength, change in cognition/mental status/memory, or weakness

Musculoskeletal System
- denies deformity/swelling, redness, or arthritis

Peripheral Vascular System
- denies intermittent claudication, coldness or trophic changes, varicose veins, peripheral edema, or color change

Hematologic System
- denies easy bruising or bleeding, hx of blood transfusions, lymph node enlargement, or history of DVT/PE

Endocrine System
- denies polyuria/polydipsia/polyphagia, heat or cold intolerance, goiter, excessive sweating, or hirsutism

Psychiatric
- denies anxiety, depression/sadness, obsessive/compulsive disorder, or seeing a mental health professional

Physical Exam

Pt is AOx3, her decisional making capacity appears to be independent, can make her needs known and establish her plan of care. Looks stated age, appears malnourished w/ appropriate hygiene. She is cooperative, presents with appropriate mood and affect. Does not appear to be currently in distress.

Vitals

BP → 90/47
HR → 90 beats/min, regular
RR → 18 breaths/min, unlabored
Temp → 98.6 F (oral)
SpO2 → 97% (room air)
Height → 5'7 feet
Weight → 119.1 lbs
BMI → 18.7

HEENT

Skin
- warm and dry, w/ moderate turgor
- **surgical site w/ 10 steri strip on L hip**
- **rash on b/l groin w/ extension to buttocks**
- **sacral stage 4 pressure ulcer (15x15x3 cm)**

- **multiple unstageable pressure ulcers on LLE: L heel (7x7x0 cm), L ankle laterally (3x3x0 cm), L second toe (0.5x0.5x0 cm)**
- **multiple separate unstageable pressure ulcers on R foot dorsally & laterally: (0.5x0.5x0 cm), (1x1x0 cm), (2x2x0 cm), (2x2.5x0 cm) and (1x1x0 cm)**

Hair

average quantity and distribution

Nails

no clubbing, capillary refill <2 sec throughout

Head

normocephalic, atraumatic, non-tender to palpation throughout

Eyes

symmetrical OU, no evidence of strabismus/exophthalmos/ptosis, sclera white, conjunctiva & cornea clear, visual fields full OU, PERRL, EOMs full w/ no nystagmus
requires reading glasses only

Ears

symmetrical and normal size, no evidence of lesions/masses/trauma on external ears, no discharge/foreign bodies in external auditory canals AU, TM's pearly white/intact with light reflex in normal position AU

Nose

symmetrical, no obvious masses/lesions/deformities/trauma/discharge, nares patent bilaterally/nasal mucosa pink & well hydrated, no discharge noted on anterior rhinoscopy, septum midline without lesions/deformities/injection/perforation, no evidence of foreign bodies

Sinuses

non-tender to palpation and percussion over bilateral frontal, ethmoid and maxillary sinuses

Mouth/Throat

lips are pink, moist, w/ no evidence of cyanosis/lesions, non-tender to palpation
mucosa is pink and dry, no masses/lesions noted, non-tender to palpation, no evidence of leukoplakia
palate is intact with no lesions/masses/scars, non-tender to palpation
moderate dentition, wears upper dentures (not present on exam) **As discussed – if many are gone, note number of teeth present or note which type are missing (incisors, canines, bicuspids, tricupids) and if missing multiple teeth definitely want to note whether there are signs of gum disease.**
tongue is well papillated, no masses/lesions/deviation noted, non-tender to palpation
no evidence of exudate/masses/lesions/foreign bodies on oropharynx, partial tonsils present with no evidence of injection or exudate, uvula pink, no edema/lesions

Neck

trachea midline, no masses/lesions/scars/pulsations noted, supple, non-tender to palpation, full ROM, no stridor noted, 2+ carotid pulses, no thrills/bruits noted bilaterally, no palpable adenopathy noted

Thyroid

non-tender, no palpable masses, no thyromegaly

Chest

symmetrical, no deformities/evidence of trauma, respirations unlabored/no paradoxic respirations or use of accessory muscles noted, Lat to AP diameter 2:1, non-tender to palpation

Lungs

clear to auscultation and percussion bilaterally, chest expansion and diaphragmatic excursion symmetrical, tactile fremitus intact throughout, no adventitious sounds

Heart

JVP is <3cm above the sternal angle with the head of the bed at 30°, PMI in 5th ICS in mid-clavicular line, carotid pulses are 2+ bilaterally without bruits, S1/S2 are normal, no murmurs/extra heart sounds

Abdomen

well healed scar on RLQ s/p open appendectomy; abd flat, symmetrical, no evidence of striae/caput medusae/abnormal pulsations/masses, BS present in all 4 quadrants, no bruits noted over aortic/renal/iliac/femoral arteries, no evidence of organomegaly, no evidence of guarding/rebound/CVA tenderness

Female genitalia

foley catheter 16 Fr in place (draining clear yellow urine), rash on b/l groin w/ extension to buttocks; **need description of rash** no ulcerations, lesions or discharge noted. Internal exam for performed.

Rectal

perianal skin is red and excoriated, tenderness and fluctuation w/ palpation **Usually if you note fluctuance, you want to say more specifically where since it implies pus, blood, or fluid under the skin**; no external hemorrhoids, skin tags, ulcers or anal fissures. Pt refused internal exam.

Peripheral Vascular

skin normal in color and dry to touch upper and lower extremities bilaterally. No calf tenderness bilaterally, equal in circumference. Homan's sign not present bilaterally. No palpable cords or varicose veins bilaterally. No palpable inguinal or epitrochlear adenopathy. No cyanosis, clubbing/edema noted bilaterally essential to include peripheral pulses in this patient who has possibly compromised peripheral circulation (long time smoker whose ulcer is probably mostly due to immobility, but could also be compounded by underlying poor perfusion)

Mental Status

alert and oriented to person, place and time. Memory and attention intact. Receptive and expressive abilities intact. Thought coherent. No dysarthria, dysphonia or aphasia noted. Did we discuss the clock-drawing test as a brief assessment of cognition. If not, look in your Primary Care notes - it's an easy and helpful test for memory, ability to maintain attention, and screens for apraxia which is often present in dementia.

Cranial Nerves

I - Intact no anosmia.

II- VA 20/20 bilaterally. Visual fields by confrontation full. Fundoscopic + red light reflex OS/OD, discs yellow with sharp margins. No AV nicking, hemorrhages or papilledema noted.

III-IV-VI- PERRL, EOM intact without nystagmus.

V- Facial sensation intact, strength good. Corneal reflex intact bilaterally. As discussed, mostly used nowadays to document likelihood of death.

VII- Facial movements symmetrical and without weakness.

VIII- Hearing grossly intact to whispered voice bilaterally. Weber midline. Rinne AC>BC.

IX-X-XII- Swallowing and gag reflex intact. Uvula elevates midline. Tongue movement intact.

XI- Shoulder shrug intact. Sternocleidomastoid and trapezius muscles strong.

Motor/Cerebellar

full active/passive ROM of UE b/l and RLE without rigidity or spasticity. L hip flexion 60 degrees, L knee flexion within functional limits. As discussed, need a little more here – can be included after your exam from the PT note. Normal muscle bulk and tone. No atrophy, tics, tremors or fasciculations. Strength is diminished bilaterally (3/5 throughout). Able to stand unsupported for 10 sec w/ max assist. Unable to perform ambulation status. Coordination by RAM and point to point intact bilaterally.

Sensory

intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally.

Reflexes	**R**	**L**		**R**	**L**
Brachioradialis	2+	2+	Patellar	2+	2+
Triceps	2+	2+	Achilles	2+	2+
Biceps	2+	2+	Babinskineg	neg	
Abdominal	2+/2+	2+/2+	Clonus	negative	

Musculoskeletal system

no soft tissue swelling, erythema, ecchymosis, atrophy It's hard to imagine there isn't some asymmetry of the LE muscles, or deformities in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted throughout. FROM of all upper and RLE, diminished ROM of LLE. No evidence of spinal deformities.

<u>Assessment/Plan</u>

73 y/o F, current smoker w/ 27 pack-year hx, w/ PMHx of RA and HLD admitted to Gouverneur Skilled Nursing facility on 4/2/19 from Mount Sinai Beth Israel Hospital where pt was admitted on 3/4/19 for L hip fx s/p fall. Pt was found to have L femoral neck fx, extended-spectrum beta-lactamases E. Coli sepsis, AKI, hypernatremia, DVT b/l, PE, stage 4 sacral ulcer, deep tissue injuries to LE b/l and perianal fistulas. Pt was admitted to Gouverneur SNF for skilled rehab services, including extensive assist w/ ADLs and wound care. Long-term goal is for pt to be discharged to the community w/ appropriate support. Need assessment of each of the issues under assessment – what is the status of each Dx/issue. Then plan grows out of that.

1. Fall and Safety precaution in places
   - Bed exit and personal arm in place

2. Continue Daily Multidisciplinary rehabilitation
   - Monitor pt, V/S, assist with ADLs, and ambulation

- Pressure ulcer prevention: pressure reducing device for chair and bed; turning/repositioning program
- Fall precaution
- Aspiration precaution
- Use Bell for safety and help when needed - keep within reach
- Bed at lowest position
- Anticipate and meet pt needs
- PICC line care
- Foley care

3. L femoral neck fx
   - PT/OT 1-2 hrs/day
   - f/u w/ ortho
   - continuous foley catheter
   - body aligner to position pt in side lying, change position every 2 hrs

4. Malnutrition
   - Trend electrolytes
   - Monitor PO intake
   - Incorporate ensure Enlive TID and Juven 1 pack BID

5. Pain ppx – continue oxycodone as above

6. DVT ppx – continue Eliquis as above

7. Constipation ppx – continue senna, miralax, bisacodyl, and fleet enema as above

8. HLD – continue atorvastatin as above

9. RA
   - hold off on enbrel b/c it can compromise immune system function and delay ulcer healing
   - f/u w/ rheumatology

10. Wound care
    - RLE & LLE ulcers:
      - apply betadine paint to ulcers and cover w/ dry protective dressing and PRN
      - mepilex dressing to b/l heels daily and PRN for protection
    - Sacral ulcer:
      - apply santyl and clindamycin gel 50/50 after cleansing w/ normal saline BID, cover w/ 4x4 and abd dressing BID and PRN, apply mepilex dressing on top
      - continue augmentin as above until 9/27/19
      - Risa-Bid as above for C. Diff ppx
      - f/u w/ ID for wound consult
    - Heel booties to b/l heels for protection
    - Rash on groin & buttocks
      - continue miconazole cream as above
    - L hip surgical site wound
      - apply betadine paint, cover w/ telfa dressing daily and PRN

11. Current smoker
    - Smoking cessation education

<u>Patient Education/Follow-up care</u>

These are your follow-up appointments:

Primary Care Provider

Dr. Calveron
April 11, 2019 9:20AM
212-627-7560

Rheumatology (call to schedule an appointment)
Dr. Fafalak
212-933-0071

Ortho
Dr. Komberda
April 15, 2019 1:00PM
Mount Sinai
10 Unon Sq E, Suite 3K
212-844-6400

Infectious Disease
Dr. Nadim Salomon
April 16, 2019 2:00PM
10 Union Square E
New York, NY 10003
212-844-8105

Heme (call to schedule an appointment)
Dr. Rappoport
36 7th Ave
New York, NY 10011
646-486-2200

Pulmonary (call to schedule an appointment)
Dr. Patrawalla
10 Union Square E, Suite 2A
New York, NY 10003
212-420-2377

We will assist you w/ scheduling of any appointments that are not yet scheduled and will arrange for proper transportation.

Due to your several ongoing wounds, which led to an infection in the blood, you will be taking antibiotics for several months.

The medical staff will care for your wounds daily. You will stay at our facility for at least several months to reestablish activities of daily living and in order for the wounds to heal.

You will be performing physical and occupational therapy which will help you with the recovery after your hip surgery.

When getting nearer discharge, we will assist you with examining your living arrangements and in getting you some assistance.