Alena Rakhman
LTC Rotation 3 H&P 3

**Good case. Structurally good H&P. Now need to get to a more professional level.**
**Particularly important issues:**

- **Need to comment on the areas of most concern – pelvic and wrist fractures, brain injury/cognition – document more precisely their status in PE and whether they are improving/not improving in the Assessment section**
- **As before, need specific locations of wounds, scars, lesions, etc. This will be really important in Surgery.**
- **Beware the template – it can be very easy to list normal that aren't or include exams not done – this is really dangerous from a medical care and a medical-legal point of view.**
- **The comment about sacro-iliac fixation in the Assessment is concerning. It doesn't seem like it's accurate so this is a big deal again from a medical care and a medical-legal point of view.**

Identifying Data
Full name: R.A.
DOB: 02/12/1945
Date & time: March 26, 2019 3:00 PM
Location: Gouverneur Skilled Nursing Facility
Religion: Catholic
Marital status: Single
Source of information: Self/pt's sister/medical records
Source of referral: Non-reliable patient Usual phrase is "unreliable historian" – and say briefly why (in this case "brain injury")

CC: traumatic brain injury w/o LOC s/p pedestrian struck MVA x23 days use of "x" means the thing is continuous so not appropriate here. Usually for this kind of event, you just give the date → "…struck MVA (3/2/19)". The rule is S/P → a specific date. Continuous condition (e.g. HTN) can use "x __ days/months/years"

HPI:
74 y/o non-reliable F w/ no reported PMHx admitted to Gouverneur Skilled Nursing facility on 3/25/19 from Bellevue Hospital where pt was admitted on 3/2/19 for traumatic brain injury w/o LOC s/p pedestrian struck MVA. As per pt's discharge paperwork, she was initially brought in by EMS to the ED as a level 2 trauma. Per EMS, car was going approximately 20-25 mph. GCS scale in the ED was 15. Pt was found to have L basal cistern SAH, L lateral ventricle and L>R convexity SAH and L frontal contusions, L superior & inferior and R inferior pubic rami fxs, L sacral fxs, and L distal radius fx. She was admitted to the surgical intensive care unit for category 2 traumatic brain injury and management of pelvic injuries. Hand surgery performed reduction and stabilization of the distal radius fx. Ortho performed L percutaneous sacroiliac joint screw fixation on 3/6/19. On 3/8/19 pt was admitted to an acute rehab unit where she received PT/OT & speech language therapy assistance for at least 3 hrs/day x7 days/wk. Was prescribed trazodone after experiencing periods of insomnia w/ improvement. Pt was making significant functional gains throughout her rehab course. She also remained medically stable throughout rehab. She removed her wrist cast twice and required long-arm cast placement by hand surgery to prevent any further self-removal. Her sutures from where? were removed on 3/18/19. Pt is nonreliable, kept stating that she is in "queens" Queens and had periods of forgetfulness. Pt's sister was contacted over the phone and expressed plans to look for assisted living for the pt. Pt is admitted to Gouverneur SNF to address cognitive (impaired attention and memory) and functional deficits (impaired ADLs and mobility). Per pt's sister, prior to the incident pt was ambulating independently and had no functional deficits. Denies fever, chills, CP, palpitations, SOB, wheezing, HA, dizziness, vertigo, visual disturbance, sensory disturbances, weakness, N/V/D, or recent travel.
Good flow overall and good capture of information. As with the other case, it might be (in my opinion) helpful to know that she was independent and without functional limitations at the start of the story.

ADVANCE DIRECTIVE – FULL CODE

PMHx/PSHx

- No reported past medical/surgical history

Childhood illnesses

- Pt unable to recall

Immunizations

- Influenza - pt unable to recall
- Pneumovax - pt unable to recall
- PPD - refused (unable to recall any detail about TB exposure)

Medications

- Acetaminophen 650 mg tab (PO Q6H PRN) for moderate pain
- Heparin Sodium 5,000 units (SQ Q12H) for DVT ppx
- Trazodone 50 mg tab (PO QHS PRN) for insomnia

Allergies

- NKDA
- No environmental or food allergies

Family History

- Mother → died from natural causes, 92
- Father → died from MI, 69
- Sister → alive and well, 65
- 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 apartment in Queens. She does not have a Home Health Aide.
- Occupation – Was an usher for a theater company before retirement.
- Habits – Denies hx of smoking cigarettes, drug or alcohol abuse.
- Education – College.
- Diet – regular diet.
- Exercise – walks around her neighborhood every other day.
- 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

*Head*

- **head trauma refer back to HPI**; denies HA or vertigo

*Eyes*

- **wears corrective lenses;** denies visual disturbance, lacrimation, photophobia, pruritus, or use of glasses When using a template, beware of the negatives that aren't negative – here she uses corrective contact lenses (BTW does she have them with her?)

*Ears*

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

*Nose/Sinuses*

- denies congestion, rhinorrhea, epistaxis or obstruction

*Mouth and throat*

- **wears upper and lower 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

*Genitourinary System*
- denies urinary urgency, urinary frequency, flank pain, nocturia, oliguria, polyuria, dysuria, incontinence, or awakening at night to urinate

*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 would want to refer back to the HPI here as well

Physical Exam

Pt is AOx2, disoriented to place. Well developed and well groomed. She is cooperative, presents with appropriate mood and affect. Does not appear to be currently in distress.

Vitals

BP → 152/70
HR → 87 beats/min, regular
RR → 19 breaths/min, unlabored
Temp → 97.5 F (oral)
SpO2 → 97% (room air)
Height → 5'1 feet
Weight → 96 lbs
BMI → 18.1

HEENT

Skin

skin is of normal color, dry, w/ good turgor
healed laceration of 2 cm on L forehead describe more precisely
old healed surgical scars on b/l hips (10 cm R, 8 cm on L) If these are from the repairs to her pelvis, are they really on her hips? Need more precise location to make the story coherent. Otherwise it reads as if she had some other type of (hip) surgery. I'm not familiar with the techniques, but I'm guessing you don't enter via the hip to get at the rami. Need landmarks – underlying pelvis bones, distance from the midline, distance from the inguinal crease or similar.

Hair

average quantity and distribution

Nails

no clubbing, capillary refill <2 sec throughout

Head

normocephalic, atraumatic ←May be true, but I'm wondering about the template issue again. 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 Just want to emphasize that in head trauma cases, this part of the exam is really important

**wears contact lenses**

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 As discussed, I don't know what moderate means in this context – see my comments on the other H&P, wears upper and lower dentures (not present on exam) dentures vs. bridge(s)**

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

abd flat, symmetrical, no evidence of striae/caput medusae/abnormal pulsations/masses/scars, 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

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 Peripheral pulses really essential here – need to document perfusion of the LEs after this type of injury

Mental Status

alert and oriented to person and time, disoriented to place. Mini-mental states examination 18/30, indicative of mild cognitive impairment Look this up – I don't think that's in the mild range. Long term memory appears intact, Short term memory appears moderately impaired. Receptive and expressive abilities intact. No dysarthria, dysphonia or aphasia noted.

Cranial Nerves

I - Intact no anosmia. Did you actually test this? If not, don't report it – CNs are obviously very important in this pt.

II- VA 20/20 bilaterally With lenses?. 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.

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 RUE and LE b/l without rigidity or spasticity. ROM of LUE limited due to hard cast. Normal muscle bulk and tone If casted, can't say this – and there is likely some atrophy under the cast. No atrophy, tics, tremors or fasciculations. Strength equal and appropriate for age bilaterally (4/5 throughout) Also can't say this. No Pronator Drift. Able to ambulate 100 ft in 5 min. Coordination by RAM and point to point intact bilaterally. Romberg test w/ eyes open and eyes close 20 seconds.

Sensory

intact to light touch, sharp/dull, vibratory, proprioception, point localization, extinction, stereognosis and graphesthesia testing bilaterally. Really important to document that vibration and sensation to pain are intact in distal LUE

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

This should be reported as "Plantar reflex normal" or "Plantar Reflex downgoing" – Babinski refers only to the positive finding of an upgoing toe (may seem picky, but some attendings are really focused on this – you will impress them if you do it correctly and not impress if you don't)

Musculoskeletal system

LUE in hard cast, pulse, motor, neuro sensation intact to touch This is a neuro finding – belongs above. No soft tissue swelling, erythema, ecchymosis, atrophy, or
deformities in bilateral upper and lower extremities. Non-tender to palpation, no crepitus noted throughout. FROM of LE b/l and RUE, limited ROM of LUE due to hard cast. No evidence of spinal deformities.

Pertinent Diagnostic Studies (laboratory, imaging)

**CT findings: Need date**

1. Traumatic subarachnoid hemorrhage. Small subdural hemorrhage. There are multiple foci of intraparenchymal hemorrhage in the cortex and deep white matter.
2. No acute cervical spine injury.
3. No acute facial fractures. Small left frontal subgaleal hematoma.
4. No acute thoracic injury. Intact aorta.
5. Combined later (lateral?) compression and anterior-posterior compression fracture with a small focus of active extravasation inferior to the pubic symphysis.
6. No acute thoracolumbar spine injury.

**3/3/19**

**L wrist fx:**

- Comminuted, impacted L distal radius fx w/ intraarticular extension

**3/11/19**

**L wrist fx:**

- A cast overlies the L extremity, obscuring fine osseous detail. Status post RUE (LUE?) reduction for comminuted, intraarticular fxs of the distal radial diametaphysis. There is again noted to be mild displacement of the dominant distal fx fragment posteriorly by 1 cortical width. Additional smaller fx fragments are displaced medially and laterally by one cortical width as well.

Assessment/Plan

74 y/o F w/ no reported PMHx admitted to Gouverneur Skilled Nursing facility on 3/25/19 from Bellevue Hospital where pt was brought in by EMS as a level 2 trauma on 3/2/19 s/p pedestrian struck MVA. Pt was admitted for pelvic polytrauma and category 2 traumatic brain injury w/o LOC, s/p sacroiliac fixation (this is not what your HPI says) and reduction & stabilization of L distal radius fx. Pt is admitted to Gouverneur SNF to address cognitive (impaired attention and memory) and functional deficits (impaired ADLs and mobility). Pt is adjusting well to the facility. She tends to wander around, wanderguard placed on R wrist.

Pt presents w/ verbal perseverations not noted in PE – should be part of the mental status assessment and appears to have selective memory. Barriers toward discharge to the community include pt's inability to make consistent decision toward her care, requirement for high levels of care, increased risk of falls/rehospitalization, limited community support and no prior home care services. Good – assessment here. Need assessment of each issue below as well as noted

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

3. Pelvic fractures – their status
4. Pain management Pain controlled or not – continue Acetaminophen as above

5. DVT ppx – continue Heparin Sodium as above

6. Insomnia Is Trazodone effective for her or not?
   - continue Trazodone as above
   - consider d/c if insomnia improves

7. L distal radius fx Current status of healing
   - Weight bearing as tolerated through humerus but not wrist
   - f/u w/ hand ortho

8. Surgical wound care Is it healing as it should?
   - Monitor site until steri strips fall off
   - Advise pt not pull, tug or rub on the area
   - f/o w/ ortho

9. Functional deficits/Impaired judgement Is there improvement/status unchanged/etc.
   - Continue PT/OT and speech language therapy
   - Wanderguard placed on R wrist for wandering precaution
   - Discuss w/ pt's sisters long-term care stay for pt

Patient Education/Follow-up care

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

Continue physical therapy, occupational therapy and speech language therapy in order to continue to improve your condition.

We will assess when it would be optimal for your health and well-being to be discharged from our facility. We will assist you with setting up continuation of care.