INTERPROFESSIONAL CASE APPLICATION

FACILITATORS

Group 1:	Sue Tebb (SLU School of Social Work) and Barbara Stone (ATSU School of Nursing)
Group 2:	Helen Lach (SLU School of Nursing) and Marla Berg-Weger (SLU School of Social Work)
Group 3:	Milta Little (Geriatrics Division) and Kim Levenhagen (SLU Department of Physical Therapy)
Group 4:	Janet Head (ATSUN/Area Health Education Center) and Cindy Matlock (SLU Department of Occupational Therapy)
Group 5:	Karen Heath (SLU Department of Family & Community Medicine) and Jan Palmer (SLU School of Nursing)

AGENDA

3:00 - 3:20	Introduction to case (auditorium)
3:20 - 3:30	Relocate to breakout rooms and introductions
3:30 - 4:15	Discuss case and develop a response
4:15 - 5:00	Present case plan for discussion/De-brief
5:00	Adjourn

YOUR TASK

Your team is about to take over the care of Mr. Henry Williams who was admitted to Poplar Bluff Regional Medical Center 5 days ago with an acute episode of shortness of breath as a result of chronic obstructive pulmonary disease. Henry is about to enter a week-long stay for pulmonary rehabilitation. Your task is to:

1. Create an interprofessional team to care for Henry during his pulmonary rehabilitation stay.
2. Plan for Henry's discharge back into the community.

In developing the care for Henry please ensure that you consider:

- The composition of the team, identifying the roles and responsibilities of those involved
- How you will ensure effective teamwork
- How you will ensure effective communication
- How you will ensure that you place the interests of Henry and his family at the center of interprofessional health care delivery.
- How you will plan for quality improvement and patient safety.

The 4 core competencies of interprofessional collaborative care will provide you with guidance on the issues to consider.

- Roles and Responsibilities
- Interprofessional Communication
- Values and Ethics
- Teams & Teamwork

THE CASE

Poplar Bluff

Poplar Bluff

Henry and Ertha Williams live in **Poplar Bluff**, Missouri, a town of about 17,000 in southeastern Missouri. Known as the “Bootheel” part of Missouri, Poplar Bluff is located in **Butler County** (population 43,000) just above the “instep” of the boot.

Historically a cotton growing and farming area, the area’s economy is now more diversified and in the past 5 years, PB has been linked via 4 lane road to the St. Louis area—about 2.5 hours north and Memphis TN, 2.5 hours south. The community is home to Three Rivers Community College which has several health professions training programs; the John J. Pershing Veterans Administration Hospital, a state Regional Center which provides assessment and consultative medical resources especially for developmentally disabled children and adults. Additionally, two major physician clinic groups, numerous home health service agencies, dental providers, and other health care/related agencies serve PB residents.

Currently two hospitals serve the area. The older of the two hospitals--Poplar Bluff Regional Medical Center--provides a full range of primary, acute, and critical care services. PBRMC’s new Senior Extra program was established to help older area residents stay active, be involved, and keep up with health trends and medical information. Senior Extra membership is free. Activities offered through the Senior Extra program include screenings, medical information, events and support activities such as Diabetes Education Class, Senior Extra Lunch & Learn, Community Lunch & Learn, Wii Bowling, Donuts/Dominoes, Bingo Birthday Bash, I Can Cope Cancer Support Group.

SENIOR CENTER: Housing options in the area include low-cost housing through the local Poplar Bluff Housing Authority which is an independent agency that maintains 189 apartments for seniors and 286 family units at the Twin Towers, Hillcrest and Wilson housing centers. There is also a recreation/ exercise area, dining area open to the public for lunch and a library with Internet access. Its governing board is appointed by the City Council. Items furnished include stove, refrigerator, trash service and laundry facilities. Activities include bingo, ceramics, pool/billiards room, and a library with computer and Internet access. The cafeteria at the Senior Citizen Center at Twin Towers is open to the public for lunch. No reservations are required. Cost is $3.00/person for anyone over 60 and their guest or $3.25 for

others.

Poplar Bluff is the home of Linda Bloodworth-Thomason the creator/producer of the popular ‘80s series, “Designing Women.” Other notables from the PB area include: Leroy Griffith: theater owner and film producer; Tyler Hansbrough: NBA basketball player for the Toronto Raptors who won the 2009 NCAA Men's Division I Basketball Tournament at UNC Chapel Hill; Ben Hansbrough: NBA Basketball player for the Indiana Pacers; Tim Lollar: professional baseball pitcher; Scott Innes: radio broadcaster and voice actor for *Scooby-Doo;*Derland Moore: professional football player.

THE WILLIAMS FAMILY

Some words from Ertha
When Henry and Ertha's neighbor took Ertha home when Henry was admitted to the hospital. They were waiting for Betty to come back from the hospital:

Ertha to neighbor: “It’s so nice to have such good neighbors when something like this happens. I haven’t heard from Betty, we need to tell her what happened. (Whispers) You know, it’s so frustrating when I can’t help out; you know, with my condition and all… I really need to call Betty, get to the hospital, and take care of things at the house for when Henry comes home. It’s so nice to have such good neighbors in times like these…”

Henry’s Thoughts on Day 4 and 5 in hospital

Day 4: I'm feeling pretty frustrated with all this time away from Ertha. I'm also getting a bit scared about leaving this place and going to the next. What if all these treatments don't work? What happens if I have to come back here again, what will happen with Ertha? Makes my head spin. I just want to go home. I want to be there, instead of here, with my wife. With so many things that seem uncertain, our future looks like a bigger hill to climb every time we look at it.

Day 5: My goodness, how will Betty be able to keep up. She's already got her hands full with her career and her son, our grandson. Now she has to worry about helping us get settled. I'll be praying for her strength. Well, today they are getting me ready to move over to the rehabilitation center. I hope they know what they're doing. And I sure hope I get to see Ertha sometime soon. I miss her. I hope she doesn't have any trouble remembering me. I really do miss her.

THE INTERPROFESSIONAL TEAM

Nursing

Physician/PA

Occupational Therapy

Physical Therapy

Speech & Language

Dental

Health Education

SW/Psychology/Counseling/Gerontology

Others

Nursing Plan of Care for Henry

Nursing Diagnoses	Nursing Interventions	Nursing Outcomes
Alteration in respiratory status secondary to exacerbation of COPD Activity Intolerance. Anxiety Risk for depression. Caregiver role strain	Respiratory monitoring: Monitor rate, rhythm, depth, and effort of respirations. Fluid volume, deficient: Fluid/electrolyte management; Intravenous Therapy; Activity Intolerance: Energy management, exercise promotion, self-care assistance. Anxiety reduction: Use a calm, reassuring approach. Clearly state expectations for patient's behavior. Identify when level of anxiety changes. Listen attentively. Create an atmosphere to facilitate trust. Coping enhancement: Appraise the patient's understanding of the disease process; appraise the patient's needs/desires for social support. Caregiver support. Family support. Counseling. Referral. Mutual goal setting: Identify with patient the goals for care; explore with patient ways to best achieve goals.	Respiratory Status: Maintain at ≥88% at 2 liters of O2 by nasal cannula. Maintain at 3 (moderate deviation from normal) Endurance: Maintain at 3 (moderately compromised). Energy Conservation: Balances activity and rest. Maintain at 3 (sometimes demonstrated). Anxiety Level: Verbalized anxiety. Maintain at 3 (moderate) Depression Level: Depressed mood. Increase from 3 (moderate) to 2 (mild). Family Coping: Manages family problems. Increase from 2 (rarely demonstrated) to 3 (sometimes demonstrated). Environmental management: home preparation: Consult with patient and caregivers concerning preparation for care delivery at home.

NURSING NOTES Day 1

ADMISSION TO HOSPITAL:

1. Alteration in respiratory status: apply oxygen, 2 liters/minute by nasal cannula. Assess oxygen saturation levels. Initiate and monitor Lactated Ringer IV fluids @ 50 mL/hr.; encourage oral fluids of ___ cc per day, and ___ diet with __ calories per day. Assess/report lab work for ABG.

2. Activity Intolerance: Discuss bed rest with call light in reach; call for assistance for trips to bathroom or ambulation. Assign a patient care technician (PCT) to assist Henry with bathing, ambulation,

elimination, and obtaining vital signs each shift. Monitor patient's intake and output, weight, appetite, elimination, & vital signs. Request referral for physical therapy for evaluation; Request referral for registered dietician for food preferences and calories needed;

3. Anxiety; 4.Risk for depression: Assess depression, using geriatric depression scale. Assess anxiety, using the general anxiety disorder. Anxiety Reduction: Use a calm, reassuring approach.

5. Caregiver role strain: Request referral for psychiatric social worker or psychologist to discuss anxiety and risk for depression and caregiver role strain. Mood management: evaluate mood. Begin assessing patient's discharge needs.

Day 3

1. Alteration in respiratory status: apply oxygen, 2 liters/minute by nasal cannula. Assess oxygen saturation levels. Monitor Lactated Ringer IV fluids @ 50 mL/hr.; encourage oral fluids of ___ cc per day, and ___ diet with __ calories per day. Assess/report lab work.

2. Activity Intolerance: Discuss bed rest with call light in reach; call for assistance for trips to bathroom or ambulation. Patient care technician (PCT) to assist Henry with bathing, ambulation, elimination, and obtaining vital signs each shift. Monitor patient's intake and output, weight, appetite, elimination, & vital signs. Implement physical therapy's plan for activities; Implement registered dietician's plan for meals/snacks;

3. Anxiety; Coping enhancement: Assess anxiety, encourage expression of feelings. Use a calm, reassuring approach.

5. Caregiver role strain: Discuss discharge plans for caregiving, housing, meals, and expenses. Mood management: evaluate mood.

Day 5

Prepare for discharge from hospital to inpatient pulmonary rehabilitation.

Discuss readiness for enhanced self-care at the rehabilitation facility, including feeding, toileting, and dressing.

Discuss client's plans to obtain an apartment with supportive services for Betty and client.

Discuss plans for medication administration and the need for oxygen at the rehab facility and in a home setting.

Discuss concerns about paying for services (housing, meals, medications, oxygen, caregiver for Betty.)

PHYSICIAN & PA

Henry is a 69 yo man with COPD who presents to the ED with a three-day history of progressive dyspnea, cough, and increased production of clear sputum. He usually coughs up only a scant amount of clear sputum daily and coughing is generally worse after rising in the morning. He denies fever, chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. He treated himself with albuterol, but respiratory distress increased despite multiple inhalations. Upon arrival to the ED, there were few breath sounds heard with auscultation and the patient was so short of breath that he had difficulty climbing up onto the examiner's table and completing a sentence without a long pause. He was placed on 4L oxygen via nasal cannula and given nebulizer treatments.

PMH
HTN X 10 years
COPD diagnosed 6 years ago
Occasional episodes of acute bronchitis treated as outpatient with antibiotics.
History of TB, asbestos exposure, occupational exposure, asthma

Family History
Father died of lung CA
Mother is alive, age 80, also has COPD and is being treated with O2.
One sister, developed heart disease in her 50s.
Only son, deceased, good relationship with daughter-in-law Betty.

Social History
Married to Ertha for past 47 years.
2 pack/day Camel smoker for 37 years, has cut back to 5 cigarettes/day since he was diagnosed with COPD and is now willilng to consider complete smoking cessation.
History of alcohol use, a social drinker for the past 15 years.

ROS
Denies weight loss but has lost 25 pounds in the last 7 years.
Denies progressive fatigue, loss of libido, morning headaches, and sleeping problems.

Skin
Cold and dry.
(-) cyanosis, nodules, masses, rashes, itching and jaundice.
(-) ecchymoses and petechiae
Poor turgor

HEENT
PERRLA
EOM's intact
Eyes anicteric; Normal conjunctiva
Vision is satisfactory with no eye pain
Fundi without AV nicking, hemorrhages, exudates, and papilledema
TMs intact
(-) tinnitus and ear pain
Nares clear
(+) pursed lip breathing
Oropharynx clear with no mouth lesions; Yellowed teeth
Oral mucous membranes very dry
Tongue normal size; No throat pain or difficulty swallowing

Neck and Lymph nodes
Neck supple but thin
(+) mild JVD
(-) cervical lymphadenopathy, thyromegaly, masses and carotid bruits

Chest and Lungs
Use of accessory muscles at rest; Barrel chest
Poor diaphragmatic excursion bilaterally
Percussion hyper-resonant
Poor breath sounds throughout
Prolonged expiration with occasional mild, expiratory wheeze
(-) crackles and rhonchi
(-) axillary and supraclavicular lymphadenopathy

Heart
Tachycardic with normal rhythm
Normal S1 and S2
Prominent S3
No rubs or murmurs

Abdomen
(+) hepatosplenomegaly, fluid wave, tenderness, and distension
(-) masses, bruits, and superficial abdominal veins
Normal BS

Genitalia and Rectum
Penis, testes, and scrotum normal
Prostate slightly enlarged, but without nodules
Heme (-) stool
No internal rectal masses palpated

Musculoskeletal and Extremities
Cyanotic nail beds
(-) clubbing
1+ bilateral ankle edema to mid-calf
2+ dorsalis pedis and posterior tibial pulses bilaterally
(-) spine and CVA tenderness
Denies muscle aches, joint pain, and bone pain
Normal range of motion throughout

Neurological
Alert and oriented
Cranial nerves intact
Motor 5/5 upper and low extremities bilaterally
Strength, sensation, and DTR intact and symmetric
Babinski downgoing
Gait steady
Denies headache and dizziness

Lab test and Chest X-ray to follow as well as ABG's.

OCCUPATIONAL THERAPY

Initial Evaluation, Day Two

S: Pt. states sarcastically, “Sure…. I feel great… as long as I don’t try to do anything.”

O: OTR received orders for eval and treat with specific tx plan to follow. At time of initial eval, pt. was sitting up at the side of the bed, attempting to finish his lunch. Speech was halting and he was obviously SOB in his attempts to answer the therapist’s questions. He revealed that he lives in a one story apartment with his wife, Ertha, who has dementia. According to the chart, pt. has a hx of COPD, CVD, asthma, HTN, and is a past smoker. He has dentures , wears bifocals, and has hearing aids, but complains they do not work well. Pt. is on O2, 2l per nasal prong and according to nursing notes has had sat rates generally around 90% at rest. Pt. views himself as generally independent but struggling to keep up himself, attend to his wife, and sustain the house, yard, and car. He revealed past work as an engineer in the transit department, but retired 3 years ago. He c/o feeling a bit restless and bored with his life and the monotony at home. He states his retired years are turning out to be much different than the travel and motor home trips he had planned with his wife 10 years ago, before it was evident that she was developing dementia.

Pt. was assisted to stand when he suddenly announced he needed to go to the bathroom and was not sure he would make it in time. He became slightly dizzy but could not be persuaded to stop and count to 10 before proceeding. He ambulated quickly and somewhat impulsively/ recklessly to the bathroom with FWW, O2, and contact guard for safety as he would not stop and allow OTR to use a gait belt. Once in the bathroom he lowered himself onto the toilet quickly and with poor control. OTR gave pt. privacy and he had a BM. He apologized that he could not reach very well in order to wipe himself. 02 sats were 80 and he was more SOB and fatigued. OTR and CNA assisted pt. to ambulate 20 ft. back to bed and allowed pt. to rest for 30 mins. OTR resumed eval and pt. stated he felt better. O2 sats then 92 %. Pt. stated that being SOB has been typical for him in recent months, but that he usually can perform most ADL if he takes lots of breaks. He states if he pushes himself too much he becomes very shaky and anxious, wondering where his next breath is going to come from, but use of inhalers only makes him more anxious. OTR performed the Role Change Assessment (RCA) which further revealed loss in other areas such as his church participation, reductions in volunteer activities, decline in previous leisure such as woodworking, and couples bridge. He states he has resorted to use of TV dinners most nights even though he knows he should not be making a habit of them, but Ertha seems to enjoy them more than anything else he makes. Pt. complains that his house “is a wreck…. my daughter is going to think I’ve become one of those hoarders you see on TV when she sees it.” He states he has been cited by the HOA 2x in the past year for failure to keep the weeds pulled, and he finds that to be “an utter humiliation…if you could have seen the gladiolas and marigolds I used to grow” Pt. again became fatigued and OTR ended the eval at this point to be resumed tomorrow. Pt. states he has never had OT before, but hopes it can help him be able to do the things that are really important to him.

A: The following problems will be addressed by OT:

1. Low endurance for ADL, complicated by SOB with minimal exertion and lack of knowledge re COPD, breathing techniques, diaphragmatic breathing and appropriate use of O2 during ADL.
2. Role loss secondary to declining health and increasing caregiver demands

Goals:

1. Increase ability to compensate for low endurance/SOB
2. Resume, redefine, delegate or compensate in order to allow participation in meaningful roles related to leisure, self care, and caregiver.
3. Increase OOB time to approximately 3 hours per day within 1 week.

Plan:

1. Further evaluation of ADL tolerance, especially bathing, dressing, eating, hygiene, toileting
2. ADL training using principles of energy conversation, breathing, relaxation training, pacing, planning, safety with O2. Will provide book, “To Air Is Human”.
3. Assist pt. to realistically prioritize according to his actual abilities. Teach him to intentionally do a light activity, then rest, do a heavier activity, then rest and be proactive. Will discuss pt. with nursing staff and coordinate with other therapies to avoid overloading patient.
4. Refer to social work to explore possible assist with housekeeping and meal prep as well as Pulmonary Support Groups in his area.

D/C Plan: Continue OT daily for 1-2 weeks. Discuss obtaining tub transfer bench and a walker basket. Pts. financial situation is unknown at this time.

SOCIAL WORK, PSYCHOLOGY, COUNSELING, AND GERONTOLOGY

Initial Evaluation, Day Two

S: Pt. states sarcastically, “Sure…. I feel great… as long as I don’t try to do anything.”

O: SW received orders for assessment and discharge planning, specifically for referral for pulmonary support group for Mr. Williams and in-home assistance with housekeeping and meal preparation. At time of initial contact, Mr. Williams was in his room with wife, Ertha, and daughter-in-law, Betty, who were visiting him. Pt. was struggling to catch his breath so his daughter-in-law shared that he has COPD and asthma, her parents live in an apartment, her mother has dementia, and she lives in St. Louis. Once pt. regained his breath, he stated that he is independent and able to care for his wife and himself, but doesn’t “keep things up as good as she did before she got sick.” He confesses that the house and yard are a mess and he’s been cited twice by the city for tall grass and weeds. He becomes teary as he speaks about this, stating that the yard used to be a showplace. He worries what his family thinks. He prepares most of their meals but food he can heat up in the microwave. He shared that he is a retired railroad engineer and that he misses work. He and Eartha had dreamt of travelling in their RV once he retired but her “sickness” has prevented them from doing any travelling.

A: SW assessment reveals the following issues to be addressed:

1. Henry and Ertha are having considerable difficulty maintaining their independent living arrangement. Henry is adamant that he does not want to go to a nursing home or be separated from Ertha, but he acknowledges that they may not be able to continue living in the apartment. He appears to be open to the idea of moving into an Assisted Living facility.
2. Upon discharge, Henry will need to be on home oxygen and will require assistance with ADLs and IADLs for Ertha and himself.
3. Daughter-in-law Betty is a willing and capable caregiver but is experiencing caregiver-related stress and anxiety.

Goals:

1. Stabilize pt’s home environment to ensure improve safety for pt and his wife.
2. Develop long-term residential plan.
3. Develop plan for caregiver support for Henry and Betty.

Plan:

1. Referral for home health care, to include assessment of home to determine adaptations that could enhance Henry’s ability to remain in independent living.
2. Convene a family conference to discuss possible move to Assisted Living facility and to explore the possibility of Henry and Ertha moving to St. Louis. If the family is open to the move, work with Betty to identify AL options in the St. Louis area.
3. Refer Betty to the St. Louis Alzheimer’s Association for a Care Consultation assessment and information on support programs for Ertha and for Henry and herself, including respite care financial support.

D/C Plan: Coordinate with OT and PT services to develop comprehensive discharge plan.

PHYSICAL THERAPY

Initial Evaluation - Day 2 of admission

S: Pt lying semi-reclined in bed, 2 liter 02 nasal cannula, IV.

O: History: Pt. admitted yesterday with difficulty breathing due to acute exacerbation of COPD. History of COPD, CVD, asthma, HTN, hearing loss (uses hearing aids), and past smoker. Social: Lives with wife in single-level apartment. Wife with history of dementia and is being cared for by daughter-in-law while Henry is in hospital. Daughter-in-law (patient's son deceased) and grandson live a couple of hours from patient. Retired engineer from Transit Department. Patient has been active and independent and expresses interest in travelling and spending time with his family.

Precautions: Standard Examination findings:

--Cognition/language: Alert, oriented to time, place and person. Consistently follows instructions.
--Sensation: Light touch and kinesthesia intact LEs.
--Motor: PROM WNL. Tone: WNL. Strength: 4/5 hip flexors and knee extensors; 4-/5 hip abductors; 4/5 ankle dorsiflexors and plantarflexors. Balance: Independent sitting. Modified Clinical Test for Sensory Interaction in Balance (CTSIB): Able to maintain standing eyes open and eyes closed on firm surface 30 secs without increased sway; able to maintain standing eyes open 30 secs on foam without increased sway; mild to moderate increased sway standing on foam eyes closed 10 secs. Functional Reach Test: 10 inches. Stands on one leg eyes open R LE 10.5 secs, L LE 10.8 secs. Stand on one leg eyes closed for 1 sec bilaterally.
--Mobility: Independent bed mobility. Modified independent transfers moving between bed and bedside chair. Patient complained of mild dizziness when going from sit to stand, but this resolved quickly. Minimal assistance for walking to bathroom. Able to tolerate sitting for 30 minutes before requesting to go back to bed. Ambulation with 2 liters supplemental oxygen 100' level surfaces with minimal assistance, stopping 1 time momentarily to rest due to SOB. No loss of balance during walking. Slow gait speed. 02 sats at 90% prior to ambulation, 88% immediately after ambulation, and then 90% after 5 minutes of rest at end of session, all on supplemental 02. Stairclimbing/steps not assessed.

A: Major impairments and activity limitations include:
1. LE weakness.
2. Limited endurance.
3. Possible orthostatic hypotension.
4. Impaired single-leg stance balance; impaired ability to use vestibular information for balance.
5. Reduced gait speed.
6. Minimal assistance for walking indoors on level surfaces.

Goals:
1. Increase strength LEs ½ grade for increased use in ADLs.
2. No c/o of dizziness with sit to standing.
3. Maintain standing on foam eyes closed for 20 seconds to increase ability to use vestibular information for balance.
4. Maintain single leg standing balance with eyes open for 20 seconds to improve ability to perform activities such as stair climbing.
5. Tolerate sitting up in beside chair at least 1 hour without supplemental 02 and 02 sats above 90%.
6. Modified independence walking to bathroom with assistive device.
7. Ambulation with assistive device 150' level surfaces without supplemental 02, without rest periods, with 02 sats above 90% with supervision.

Plan: Therapeutic exercise and mobility training 1-2x/day. Monitor vital signs. Progress sitting tolerance and distance walked. Patient and family education. Discharge planning. Order needed equipment.

Discharge Summary - Day 5 of admission

S: "I feel stronger, but know I need more therapy so I can get back home with my family."
O: Patient has been seen 1-2x/daily during this admission. He is being D/Cd today to a rehabilitation for

continued therapies.

Examination findings:
--Cognition/language: Alert, oriented to time, place and person. Consistently follows instructions.
--Sensation: Light touch and kinesthesia intact LEs.
--Motor: PROM WNL. Tone: WNL. Strength: 4+/5 hip flexors; 4/5 knee extensors; 4-/5 hip abductors; 4+/5 ankle dorsiflexors and plantarflexors. Balance: Modified Clinical Test for Sensory Interaction in Balance (CTSIB): Able to maintain standing eyes open and eyes closed on firm surface 30 secs without increased sway; able to maintain standing eyes open 30 secs on foam without increased sway; mild increased sway standing on foam eyes closed 15 secs. Stands on one leg eyes open R LE 18 secs, L LE 17 secs. Stand on one leg eyes closed for 1 sec bilaterally.
--Mobility: Modified independent transfers moving between bed and bedside chair. Patient has been instructed to perform several ankle pumps prior to standing from sitting and to come to standing slower and he shows follow through with these recommendations independently. After day 3 of admission, had no complaints of dizziness with sit to stand. Modified independence for walking to bathroom with a front-wheeled walker (FWW). Patient is able to walk short distances without the FWW with supervision, but he feels more secure using a FWW at this time. Able to tolerate sitting for 60 minutes without supplemental 02 before requesting to go back to bed. Ambulation without supplemental oxygen 150' with a FWW on level surfaces with supervision and no rest breaks. 02 sats above 90% prior to and following ambulation. Slow gait speed continues – comfortable gait speed on 10-meter walk test is 1.1 m/sec. Able to ascend and descending a 8" step with the FWW with minimal assistance.

A: Patient made progress toward goals during this admission. Continues to have impairments of LE weakness, limited endurance, and impaired motor and sensory strategies for balance. Has activity limitations of need for assistive device for walking and reduced gait speed. Needs continued therapy to progress toward goal of independent and safe mobility. Patient has been educated in safety precautions regarding decreasing episodes of orthostatic hypotension and how to walk safely indoors with the FWW. As he becomes more mobile, he will need to experience walking in a variety of environmental conditions and his need for assistive devices will need ongoing assessment. He needs continued balance assessment and intervention. He will need a home environmental assessment prior to D/C from the rehabilitation facility to ensure independence and safety in the home. Patient's wife has observed patient in therapy but is unable to assist Henry with mobility due to her cognitive impairment. Patient needs to progress to the level of at least modified independence with all mobility in order to return to home. Patient has potential to progress to this level with intensive in-patient rehabilitation and will need to engage in life-long fitness activities as tolerated.

Goals: Progress toward goals:
1. Increase strength LEs ½ grade for increased use in ADLs. – Partially achieved.
2. No c/o of dizziness with sit to standing – Achieved.
3. Maintain standing on foam eyes closed for 20 seconds to increase ability to use vestibular information for balance. – Partially achieved.
4. Maintain single leg standing balance with eyes open for 20 seconds to improve ability to perform activities such as stair climbing. – Partially achieved.
5. Tolerate sitting up in beside chair at least 1 hour without supplemental 02 and 02 sats above 90%. – Achieved.
6. Modified independence walking to bathroom with assistive device. – Achieved.
7. Ambulation with assistive device 150' level surfaces without supplemental 02, without rest periods, with 02 sats above 90% with supervision. – Achieved.

Plan: Patient to be D/Cd to rehabilitation facility to maximize level of functional mobility and prepare for D/C to home.

HEALTH EDUCATION – HOSPITAL NOTES AND ASSESSMENTS

"As a health care professional, you assess patients all the time. But you generally do not assess a patient's family caregiver, except to identify that person as a "resource" or "informal support" when developing a discharge plan. In this traditional view, the family caregiver, who is not a client or a beneficiary and not an official part of the health care team, is typically outside the realm of professional responsibility. Like so much of health care today, that view is changing. Increasingly professionals "hand off" very sick or disabled patients to family caregivers after a hospital stay, a short-term nursing home stay, or an episode of home care services. In these transitions, especially when the patient is elderly or chronically ill, the patients' continued health and well-being depends on a family caregiver. That person must be willing and able to handle the patient's complex health, financial, legal, and social needs. Sometimes these tasks are temporary, while the patient recovers; in the case of elderly or seriously ill patients, the job can continue for months or years.

Caregiver assessment is a tool to help identify strengths and limitations to help develop a realistic plan for the next stage of care. The goal is twofold: (1) to ensure that the patient's health and well-being are maintained and enhanced; and (2) to ensure that the caregiver's capacities and needs are considered and addressed in a care plan."

Health Educators conduct "assessments"; so….

"I would recommend…" …A Caregiver's Assessment: ask Betty about…
• The caregiver's background, including age, education, employment, other family responsibilities, living arrangements.
• The caregiver's perception of the care recipient's health and functional status.
• Length of time the caregiver has been providing care; if is a new event, what the caregiver worries most about in providing care.
• Values and preferences about caregiving ("do it all myself,"; "can't deal with needles or incontinence,"; "I can't take Mom to my home because there just isn't room for another person").
• Caregiver's health status, including any limitations relevant to caregiving.
• Impact of caregiving on emotional status, finances, other family members.
• Knowledge, skills, and abilities to perform necessary caregiving tasks.
• Resources used or interested in accessing.

In introducing the assessment process to the family caregiver, the assessor should clarify the goals of the assessment and make it clear that all information (unless specified by the caregiver) will be shared with the health care team in order to develop a care plan. The assessor should also summarize the conversation, so that the family caregiver feels that his or her concerns have been heard. The assessor can emphasize the positives first, and then list the areas where some questions have been raised, and suggest a process for following up.

· Or see if Betty, because she is a nurse, would wish to use: the Caregiver Self-Assessment http://www.ama-assn.org/resources/doc/public-health/caregiver_english.pdf

HEALTH EDUCATION – TRANSITION TO REHAB NOTES AND RESOURCES

"Health Educators plan and implement evidence-based programs/interventions, so I would recommend some resources…."

Patient Education/COPD: http://www.cdc.gov/copd/

Public Health Management of COPD: http://www.cdc.gov/copd/pdfs/framework_for_copd_prevention.pdf

Once COPD has been diagnosed, goals of treatment and management include relieving symptoms; preventing and treating disease progression, complications, and exacerbations; improving exercise tolerance, daily activity, and health status; monitoring nutritional needs; and reducing premature mortality. Management should include smoking cessation and abstinence; limiting exposure to secondhand smoke, dusts, fumes, and gases; pharmacological treatment with bronchodilators and corticosteroids; supplemental oxygen therapy; pulmonary rehabilitation; collaborative self-management; and surgery. Clearly, efforts toward patient and professional education should continue to focus on promoting treatment modalities for persons with COPD as well as persons at risk for COPD.

The research/evidence behind community-based exercise/nutrition interventions for chronic disease:http://academiccommons.columbia.edu/catalog/ac:156754

We recommend the **Community Guide** as a starting point to finding best-practice interventions for nutrition/exercise programs in your community: http://www.thecommunityguide.org/index.html

In Missouri: MICA: http://health.mo.gov/data/interventionmica/

Patient Education/Resources: http://www.caringtoday.com/deal-with/resource-list-for-copd

SPEECH & LANGUAGE PATHOLOGY

DAY 2 OF HOSPITAL ADMISSION

S: Order received from physician for SLP eval and treat as indicated.

O: Oral-motor and bedside swallowing assessment completed.

A: Structures are WNL for ROM, strength, tone, and coordination for speech and swallowing. Due to COPD respiratory status is poor for efficient speech production and safe and adequate swallowing.

P: Return to eval. Pt.'s cognitive status to determine ability to learn strategies to use breath support more efficiently for speech and follow thru with dietary recommendations for safe swallow in order to maintain safe swallow and nutritional needs.

DAY 3 OF HOSPITAL ADMISSION

S: Pt. in bed demonstrating labored breathing. During brief interview Pt. reported he had some difficulty eating due to increased fatigue during mealtime. He also indicated concerns regarding meal time and caring for his wife who reportedly demonstrates an Alzheimer's dementia and can no longer cook and "does not eat well".

O: Completed brief cognitive/memory assessment utilizing the St. Louis University Mental Status Examination (SLUMS). Reviewed strategies for breath support while speaking by producing no more than 4 syllables on one exhalation. Discussed trial texture change to a soft diet is indicated with Pt. agreeing to recommendations.

A: Scores on the SLUMS indicated cognitive and memory performance WNL to learn strategies for efficient breath support for speech and swallowing. Pt. demonstrated ability to produce speech as instructed. Pt. at risk for decline in nutritional status due to poor respiratory support while swallowing.

P: Return to assess Pt.'s ability to follow thru with recommendations for speech and swallowing. Discuss concerns about nutritional status with physician, nursing and dietary.

DAY 4 OF HOSPITAL ADMISSION

S: Noted in medical chart physician's order for soft diet texture and referral to dietary. Nursing noted the Pt. is eating < 50% of his meals.

O: Reviewed SLP recommendations for speaking and swallowing with Pt. reporting he had forgotten until he saw SLP on this visit. Pt. repeated10 sentences imitating 4 syllable phrase production as demonstrated by therapist. Provided 10 additional sentences requesting Pt. to produce with adjusted phrase production (100%). Discussed dietary concerns indicated by nursing.

A: Pt. understands recommendations for speech and swallowing, but is having difficulty with follow thru. As his cognitive status appears to be WNL for tasks, emotional state may be the issue.

P: Discuss emotional status with social work. Provide Pt. with written instruction of SLP recommendations for DC to rehab.

DAY 5 OF HOSPITAL ADMISSION

S: Pt. preparing for DC with nursing assist as therapist entered room.

O: Provided Pt. with written instructions for 4 syllable speech production on each breath. Encouraged Pt. to share these instructions with rehab SLP. Recommended to Pt. that he discuss with SLP and other rehab staff how he can best meet his dietary needs and assist his wife in meeting her dietary needs and address issues with her memory loss.

A: Pt. appeared to understand instructions and agreed to address them in rehab. but may require reminders from case manager.

P: Provide copy of written instructions and recommendations for SLP to DC planner.

DENTAL

S: Henry is a 69 yo man with COPD who presents to the ED with a three day history of progressive dyspnea and cough

CC: “Loose denture and burning mouth”

Med HX:
COPD diagnosed 6 years ago.
Occasional episodes of acute bronchitis treated as outpatient with antibiotics.
History of TB, asbestos exposure, occupational exposure, asthma
He denies fever, chills, night sweats, weakness, muscle aches, joint aches and blood in the sputum. He treated himself with albuterol, but respiratory distress increased despite multiple inhalations. Patient was so short of breath that he had difficulty climbing up onto the examiner’s table and completing a sentence without a long pause. He is placed on 2L oxygen via nasal cannula and given nebulizer treatments.

Allergies: NKDA

Med HX:
O2 @ 2L per min
Lactated Ringer IV fluids @ 50 mL/hr
Albuterol Nebulizer treatment 2.5mg and Atrovent 0.5 mg in 3cc NS Q 20 minutes x 3, followed by Albuterol 2.5 mg & Atrovent 0.5 mg in 3 cc NS q 2 hours (decrease frequency, as tolerated)

Social Hx: Married to Ertha
2 pack/day Camel smoker for 37 years has cut back to 5 cigarettes/day since he was diagnosed with COPD and is now willing to consider complete smoking cessation.
Alcohol use, a social drinker for the past 15 years
Denies weight loss but has lost 25 pounds in the last 7 years.

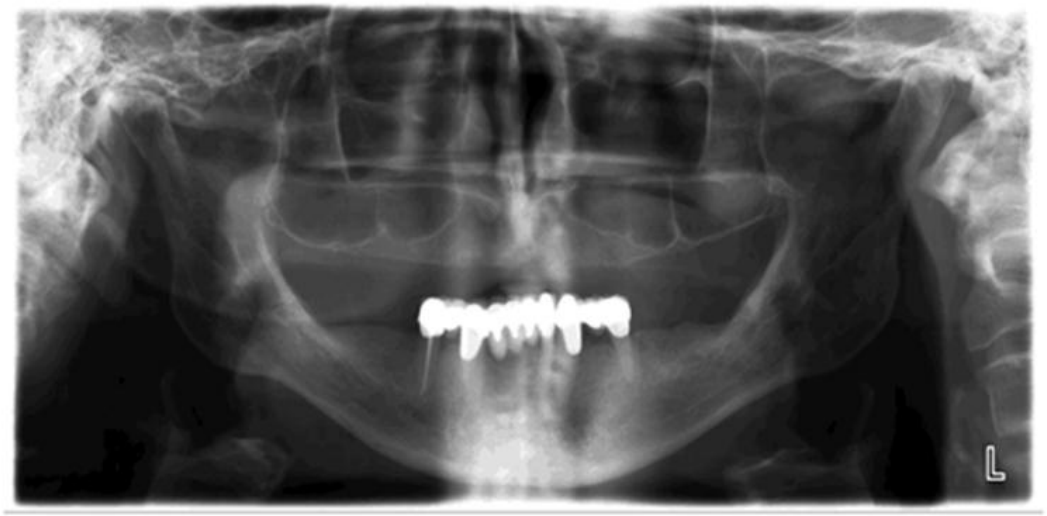
Dental Hx:
Pt has dental phobia. According to him this is the reason he lost most of his teeth. MX. Upper denture is only 4 years old but it is loose now. Pt reports that denture and partial denture do not fit well. Pt is satisfied with the look of his teeth. Pt has trouble chewing food bc denture "clicks" or comes loose while chewing. Pt reports slight sensitivity in lower L posterior occasionally, no pain. Pt doesn't remember having a dental cleaning.

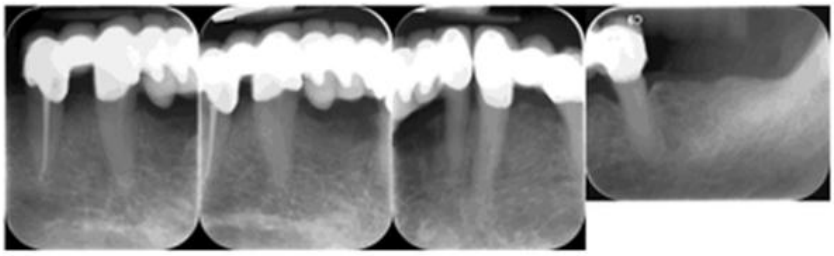
O:
BP: 133/91 mmHg P: 69 bpm
Blood sugar: 145 mg/dL

Clinical Exam:
EOE: raised, firm nodule on L temopral region near hairline 10mmx6mm, L forehead 1/2 inch x 1/2 inch scar from hx of basal cell carcinoma
IOE: Bilateral bone depression between ridge and RMP. Redness under denture along with some white patches. Redness around the corner of the mouth.
TMJ: R pop upon opening
OSC: Negative
Hard Tissue: Pt has full upper denture
Lower has FPD on lower with 29, 27, 23, 22, & 20 as retainer teeth
20: recession, check after SRP

22: check after SRP
23: check after SRP
27: recession, check after SRP
29: check after SRP
Teeth seem sound, but recheck margins of crowns after cleaning

A:
Candidiasis / Angular cheilitis
Perio Dx: Generalized chronic periodontitis
Perio Risk: moderate due to long-span bridge forces
Caries risk: high due to dry mouth
OC risk: high due to smoking





Henry Williams: Script for Introductory Monologue
(stops frequently during his story to breathe, O2 nasal cannula, coughs, appears hypoxic)

Hello, my name is Henry Williams. Life sure has changed over the last two, three years, retirement just isn't what we thought it would be… we… that would be Ertha and me. I spent my life working for the Transit Department, as an engineer for the rail system. I'm pretty proud of this accomplishment. I was on the forefront of desegregation in college and the workplace.

Ertha and I have always been active and independent, so we thought we would retire to this nice apartment and do some traveling since it's just the two of us. We haven't done much of this with my health and now Ertha's. It's been a change moving from our nice home and gardens to an apartment but we have adjusted to that OK, I guess.

We lost our only son 10 years ago to the Gulf war – that really changed our lives as well; I don't think Ertha has ever been the same. He left us a lovely daughter-in-law, Betty and a grandson, Ty, but they live a couple of hours away in the city and it's hard for us to get there. And now, Ertha is getting forgetful and it's hard to leave her. We go to the Baptist church regularly but I can't let Ertha go alone to the ladies' stuff anymore. She used to go every Tuesday. But I guess you are here to learn more about me and what's going on with my health.

Well, no one could tell me to stop smoking you know, especially when I was younger. I started smoking when I was a teenager, everyone smoked back then. I have had frequent 'bouts of colds, bronchitis, asthma and so forth but now they tell me it's COPD, whatever that means, but it sounds scary. I also have a little high blood pressure, but it's not too bad. I get so anxious now and I'm worried all the time about my wife, she is good some days and other days she can't remember things and she asks for Anthony, our son. That is so upsetting for both of us and she cries when I tell her he is gone. He was so proud to be in the armed forces but he had to go and serve overseas, he never came home to us.

I really lose my patience sometimes with Ertha. She forgets the stove is on, can't find her keys, forgets what day it is, and thinks Betty and Ty haven't visited us in years, when they were just here. I've had to watch her when she cooks, take her with me on walks. We just can't be apart and that gets frustrating. I worked every day so we were busy until we retired, now all of this heartache.

Betty took Ertha home with her while I am sick here in the hospital but we need to think about a new plan so Ertha is cared for and I am too. I don't want a nursing home but I hear there are some of those apartments where they help you some. Maybe that would be a good place for us. I sure feel bad today; I am so tired and short of breath. The doctor sent me here last night after I called his office and told him I couldn't catch my breath. My neighbor was home so she brought us in to the emergency room and took care of Ertha until Betty got here. I should be resting now; Ertha is in good hands with Betty the next few days, Betty is a nurse and can help her while I am in the hospital. I need to get some strength back. I hope my insurance will pay for this oxygen and these inhaler things I have to use when I go home. I already take two pills for my high blood pressure and a cholesterol pill, aspirin and a breathing pill. Now they want to add inhalers and oxygen? What next? I already have an inhaler I use at home and it doesn't help. Ertha needs to take a bunch of pills too.

The social worker lady said we might have to go on a waiting list before we can go into those apartments where they help you with a bath and some food. Ertha doesn't eat so well and can't cook so well anymore so help would be nice. I suppose they will put me on some diet for my breathing now and Ertha can't manage that so we could let them do our meals. I wonder if they help with the medications and baths. Ertha gets upset when I make her shower. I have to rest now; you will have to ask me questions later.

Betty's Narrative

I'm Betty, Ertha and Henry's daughter in law. Their son Anthony was my husband who was killed overseas 10 years ago in the service. I've since been raising our son Ty on my own, he is now 12 years old. Ertha and Henry were able to help me with him even though we don't live near each other. Since their health has declined it has been an uphill battle.

Currently I have Ertha here with me in St. Louis as Henry has been in the hospital with an exacerbation of his COPD. I have had to take time off work to take care of her as she cannot be left alone very long as she gets really confused and another thing is that she keeps asking for Anthony and even at times calls Ty, Anthony cause she gets so confused. Her surroundings here are unfamiliar at my house, unlike her own house where she seems to do better. I'm finding that just taking Ty to school has become a chore, and I've had to cancel many of his afterschool activities due to Ertha living here with us needing me full time to make sure she is safe and okay.

The only time that I have to myself is at night so I have not been getting much sleep as that is time I use to get things done around here. Ertha is also becoming very hard to deal with when it comes to her hygiene and it is a constant battle to get her to take a shower or even brush her teeth, she feels like she just did that and her memory is not good when it comes to that. I do not attend church here and I think Ertha misses that, Henry has also expressed his desire to go to church, but with me here is St. Louis and Henry in Poplar Bluff….

I really miss my regular routine of working at the hospital and gardening, I also feel sorry for Ty as I have not been able to spend as time with him and take him to the activities that he enjoys and for a 12 year old that is kind of hard. Looking to the future I am having a hard time and I am feeling very frustrated as I know it would be better for Ertha and Henry to stay in Poplar Bluff and attend their church and those kinds of things. Poplar Bluff is very limited when it comes to assisted living and care homes and I think they might get separated and that would break their hearts. St. Louis would be a better option I would be able to visit them and keep in touch with my family and keep it together but again I think it would be better for them to be in their own environment. I'm at such a loss at this point and don't know what to do.

Some words from Ertha

When Henry and Ertha's neighbor took Ertha home when Henry was admitted to the hospital. They were waiting for Betty to come back from the hospital:

Ertha to neighbor: “It’s so nice to have such good neighbors when something like this happens. I haven’t heard from Betty, we need to tell her what happened. (Whispers) You know, it’s so frustrating when I can’t help out; you know, with my condition and all… I really need to call Betty, get to the hospital, and take care of things at the house for when Henry comes home. It’s so nice to have such good neighbors in times like these…”

Henry’s Thoughts on Day 4 and 5 in hospital

Day 4

I'm feeling pretty frustrated with all this time away from Ertha. I'm also getting a bit scared about leaving this place and going to the next. What if all these treatments don't work? What happens if I have to come back here again, what will happen with Ertha? Makes my head spin. I just want to go home. I want to be there, instead of here, with my wife. With so many things that seem uncertain, our future looks like a bigger hill to climb every time we look at it.

Day 5

My goodness, how will Becky be able to keep up. She's already got her hands full with her career and her son, our grandson. Now she has to worry about helping us get settled. I'll be praying for her strength. Well, today they are getting me ready to move over to the rehabilitation center. I hope they know what they're doing. And I sure hope I get to see Ertha sometime soon. I miss her. I hope she doesn't have any trouble remembering me. I really do miss her.