**GERIATRIC CASE MODULE**

**(Case study for assignment)**

RW is a 75 year old male, who has been admitted to your Skilled Nursing Facility (SNF) from an acute hospital stay of 5 days – 7/23 to 7/27/14. The main admitting diagnosis for RW was recurrent syncopal episodes, along with other medical complications like failure to thrive, COPD, bipolar disorder, HTN, anxiety, depression, GI bleed, TIA v/s CVA ?, h/o alcoholism, cerebrovascular arteriosclerosis, and dementia.

**HISTORY OF PRESENT ILLNESS AND CURRENT TREATMENT**

RW had presented to the Emergency department on the 7/23/14 due to complain of an episode of syncope. RW had been one evening standing in his house, when he became dizzy and collapsed. RW had reported during his ER visit that he did not remember anything after his fall and was not sure how long he was “out”. He had been confused initially when he had been admitted to ER through EMS. During this visit, patient had also reported that ‘he had had mini strokes in the past’. According to the physician, per chart review, patient had multiple TIAs due to presence of severe major risk factors of stroke (HTN, heavy tobacco abuse). During his hospital stay, patient had been provided with education for smoking cessation with nicotine patches and with education on how his GI bleed was co-related with his NSAIDs abuse.

**PAST MEDICAL HISTORY AND SOCIAL SITUATION**

RW was admitted to the nursing home with only a discharge summary from the acute hospital and orders for PT and OT to evaluate and treat. The discharge summary provided above mentioned information and the past medical history. Past medical history also included, abdominal aortic aneurysm, GI bleed, heavy tobacco smoking of 2 to 4 packs per day, GERD, chronic dizziness and h/o skin cancer. In addition, the d/c summary mentioned that the patient had been receiving rehab services at the hospital. When you met the resident, you found that he is oriented x 2 (name, place) and is currently on 2 liters of FiO2. He reports that prior to being admitted to the hospital, he was living alone in a 1 level house and was able to complete all ADLs and functional mobility independently, by using standard cane. He reports of having no other available assistive equipment at home except cane. He presents with confusion on the number of steps that he has at home, to enter the home; but ultimately states that he probably has 1 step to enter his home.

Mr. RW appears to be sociable, answers the questions fairly well, though you notice that you have to repeat the questions few times, before you get the appropriate reply or response. He also adds that “I have been wobbly on my feet from a long time” and that “I may have had a fall or two, in the past”, with no resulting major injuries. Interestingly, the d/c summary adds that patient was receiving home health services, but according to patient, he was receiving no such services at home.

**CURRENT MEDICATIONS**

Abilify 10 mg tablet daily

Pantoprazole sodium f/c 40 mg tables, 1 tab every morning

Aspirin 81 mg 1 tab daily

Lisinopril 20 mg tablet daily

Namenda XR UD 14 mg capsule daily

Phenergan 12.5 mg 1 tab PO Q6 hours

Exelon 9.5 mg/ 24 hr patch daily. Rotate site of patches each day. Site not to be repeated within 14 days.

Divalproex SOD 125 mg x2 cap BD

AdvAIR diskus 250-50MCG DISK w/ DEV, Inhale 1 puff twice daily. Rinse mouth and spit out.

Clonazepam 1 mg tablet, four times daily

Haloperidol lactate 5 mg/ 1 ml vial , every 8 hours PRN

Meclizine HCL 12.5 mg tablet, 1 mg PO, three times daily

Acetaminophen 650 mg sup. Rect., every 6 hours PRN

Clonazepam 1 mg tablet, 4 times daily

Olanzepine UD 10 mg tab RAPDIS, every 6 hours PRN

Hydrocodon-acetaminophen 10-325 mg tab, every 4 hours PRN

Ipratropium-albuterol UD 0.5-3mg/ 3 Ampul-NEB, inhale 1 vial HHN every 4 hours PRN for COPD

Robafen 100mg/5ml Liquid. Take 10 ml by mouth every 4 hours PRN

Ventolin HFA does counter 200 INH 90 MCG HFA AER AD. Inhale 2 puffs by mouth every 4 hours PRN

Clearlax 30 once –daily doses 17 gm/ 1 dose powder

Change Nebulizer tubing weekly, when in use

**IMAGING STUDIES**

RW underwent CT brain imaging and found that CT head showed no acute intracranial abnormalities, but it did show atrophy with moderate to severe chronic ischemic small-vessel white matter disease with left parietal encephalomalacia. Endogastroduodenoscopy (EGD) revealed duodenal ulcers and severe antral gastritis.

**CURRENT FUNCTIONAL LEVEL**

RW was found to be requiring minimal assist (routinely means, requiring 25% assistance for completion of task) for bed mobility, sit <> stand transfers, pivot transfers, and for ambulation of 125 feet with Rolling Walker(RW). He presents with static standing balance of Fair (-) grade and dynamic standing balance of poor (+) grade. During ambulation, you note that his gait pattern presents with decreased cadence, decreased step length, mildly forward flexed posture, decreased heel strike, decreased foot clearance and tendency of B knee buckling during ambulation. His SpO2 at the end of 125 feet of ambulation with minimal assist with WW was found to be 92-94%. While his baseline vital signs were: blood pressure 160/92, pulse oximetry 99%, RR 18, temp 98 degrees, weight 159 pounds and height 72 inches.

 Gross strength in B hip flexors was found to be 4-/5, extensors 3+/5; knee extensors 3-/5 and ankle dorsiflexors 3/5. He was found to lack active terminal knee extension, but ROM was within functional limits. Pt was able to tolerate 8 minutes of seated activity at Edge Of Bed (EOB), prior to needing rest break. He repeatedly complained during the session, about annoying pain in L hip with ambulation.

At the end of your assessment, RW reports that “I am going back home (now)”, though he admits that he does have very limited social support available at home. You advise the patient before you leave the patient’s room that he currently needs a minimal amount of assist for performing functional mobility and request him to use his call bell to call for a Certified Nursing Assistant (CNA) and use a walker ‘with the CNA’, until he gets stronger with therapy. You also stress on the fact that him attempting to get up on his own, may result in risk for falls. He is very agreeable and reports that “I will do whatever it takes to go back home”. You go back to the nursing station after this delightful encounter with RW and write an activity order to be signed by the physician stating that patient is 1 person assist with WW on the unit. You also request the nursing staff to provide him with a WC, so that patient would be functionally mobile and will not be bed-bound.

What do you foresee as possible barriers for RW’s progress in physical therapy, based on his medications and past medical history? ( bipolar disorder, anxiety, depression, olanzapine for agitation/ aggravation/schizo/ affective disorders; meclizine for vertigo and h/o dizziness) What will constitute in your plan of care with respect to functional tests and measures, interventions, goals and treatments, etc. for RW to help him regain his prior level of function? Please justify with evidence-based literature.

**SUBSEQUENT VISITS AND DEVELOPMENTS**

After 2 weeks of stay in the SNF, RW has significantly improved with his ability to perform functional mobility and presents to be SBA with all functional mobility with RW. However, nursing staff comes and reports to you that they are no longer able to follow the activity order of providing the patient with 1 person assist, as patient does not remain in his bed or in his WC and constantly attempts to stand and ambulate without assist. He also has had a fall trying to walk from his bed to the bathroom and was lucky enough to just have had a forearm abrasion. He also had another near fall, where he was again trying to walk in his room, and it was fortunate enough that a CNA was walking past the room and was able to help the patient at right time, to prevent the fall. What safety measures/ devices/ equipment would you suggest to Nursing to use in RW’s room for his safety? (Answer: non-skid socks at all times, except when bathing; shoes to be worn at all times when OOB, pressure pad bed alarm, fall mats in the room, WC seat alarm pads, keeping the bed low, check alarms every nursing shift change)

You discuss this lack of safety precautions and associated fall risk with RW and he tells you very strongly that he ‘does not need help to walk, does not need a WC’. What will you do in this situation? This SNF has always depended on the PT to provide the activity order. Remember, you have to provide an activity order that the nursing staff will be able to follow, with the current patient’s behaviors and make sure that patient does not incur any falls. (Information: With an activity order, based on the SNF’s policy, CNAs cannot provide lesser assist than what has been recommended by PT in the activity order). What will be your course of action? What do you think about using an assistive device like ‘Merry walker’? Do you think ‘Merry walker’ may become a restraint for a patient who has dementia? If yes, then what other assistive equipment/ devices would you want to suggest for RW to improve his safety with ambulation?

Suppose, RW does not want to use ‘Merry Walker’ or any such device and wants to ambulate without it. What resources would you suggest for the nursing department and for RW for acquiring additional caregiver support? (for 24- hour caregiver help) What challenges can RW face in future, financially, if he is currently on his 61st day of Medicare Part A insurance? (after 100 days, patient’s Medicare A will no longer pay for skilled services. He will then probably shift to Medicare B, Medicaid, private insurance. How will that affect his payor reimbursement?)

( The words in blue are to be deleted, before posting this on Sakai for the students. Thank you!)