

Resident Assessment Instrument

Case Study Part I

Mrs. M's

Initial Nursing Home Admission

REVISED

JUNE 2007

Resident Assessment Instrument Case Study

A. Identification and Background Information

Mrs. M is a 90 year-old Caucasian widowed female (birthdate 01-01-12); social security number 100-10-1000) who is being admitted to the nursing home January 12, 2007. She has lived with her oldest daughter for the past three years. Recently Mrs. M has been having increased frequency of incontinent episodes. Her daughter can no longer work outside the home and meet Mrs. M's needs. Mrs. M has 4 children, 10 grandchildren, and has been widowed for 10 years. Her only child living in Missouri is the daughter that she has been living with. Mrs. M is of German origin and immigrated to the United States when she was 16. She remains closely tied to the Lutheran church in the community. She was a homemaker and graduated from high school. Mrs. M can still speak German, and when she is upset or becoming ill, she will revert to that language. She usually goes to bed around 9:00 pm and is up at 5:00 am. She denies sleeping during the day, but her daughter states that she "catnaps" especially in the afternoon. Mrs. M is responsible for her own affairs. She has private funds that she will be using to pay for her nursing home stay. Her medical insurance is Medicare Part A and B. Her daughter is named as Durable Power of Attorney for Health Care and is also named Power of Attorney for Financial Affairs. Mrs. M has made her wishes known, that in the event she should die, she is not to be resuscitated. Her physician supports her position and has written a Do Not Resuscitate (DNR) order and has written a progress note to document her conversation.

B. Cognitive Patterns

Mrs. M is alert and oriented. She was confused at night on one occasion since admission. She became restless and believed her deceased husband was present in the room. Once in the last seven days she became highly agitated, and the staff sat her up in a chair using a lap buddy to keep her from getting up unassisted. Her daughter reports that this is new behavior and she had not been confused at home prior to admission. Both long and short-term memory remains intact. She has not had problems with confusion during the day. She is able to find her own room. She recognizes staff voices but does not always recall names. She can respond appropriately to staff requests. She is currently able to identify the season.

C. Communication/Hearing Pattern

Mrs. M is deaf in her right ear and hearing aids are not useful. She can hear with difficulty if speech is directed toward her left ear. She is able to make her needs known by speaking. Her speech is clear. There is no speech deficit related to a previous stroke.

D. Vision Patterns

Mrs. M has macular degeneration and is now considered legally blind. She can differentiate between light and dark and can identify objects by shape. She wears glasses to maximize her remaining vision.

E. Mood and Behavior Patterns

Mrs. M has been occasionally tearful since admission. Her daughter states that she was not tearful at home. When asked what is wrong, she states that she misses her daughter and grandchildren. She is very concerned that she will not be able to go to her daughter's house any more since she is having difficulty making it to the bathroom. These moods are of short duration, and she can be redirected to another activity. She has been taking Prozac since 1997, when she was diagnosed with depression post CVA.

F. Psychosocial Well-Being

Mrs. M enjoys activities and attending church services. She has expressed interest in going out of the facility for weekly trips to the mall or an outside activity. She does express concern about having incontinent episodes while on an outing. She enjoys talking books and occasionally playing bingo with other residents. She has expressed interest with helping in the garden.

G. Physical Functioning and Structural Problems

Mrs. M has residual left sided weakness. Her left arm is weaker than her right, but she is able to use the left arm to help support ambulation with a walker. Her left leg is also weaker than her right but is only problematic when she is tired or ill. She is able to balance herself using a walker. She became unsteady during the standing portion of the test for balance, but she was able to rebalance herself. Due to her CHF she can only ambulate 20-30 feet before becoming fatigued and unsteady. She has limitation in functional ROM. She is not able to use her left arm to comb the back of her hair. She is only able to raise her lower left extremity to put on and remove her pants. She is able to get out of bed and ambulate to BR unassisted on most days. Limited staff assist (defined as non-weight bearing) of one person is required on average of 3 times per week for transfers and assist to the BR at least daily of moderate assist. Limited assist is also required for transfers on and off the toilet 3 times a week. She ambulates with staff to all activities and meals for 20-30 feet with minimum assist, and then staff will transport her in a wheelchair the remaining distance. She will self propel in a wheelchair short distances in her room and in the hall on days when she is too fatigued to ambulate. She is able to turn herself in bed at night. She requires minimum assistance of one person with dressing daily. She is unable to button her clothing. Occupational Therapy has recommended the use of a large handled buttonhook. She requires limited assist of one person with transfers in

and out of the bathtub. She has fallen 4 times in the past 6 months. The last fall was ten days ago and occurred when she was attempting to go to the bathroom during the night.

Mrs. M. is able to perform self-care activity and tasks of daily living. She is very slow, but desires to do as much for herself as possible. Her daughter states that her mom was independent at home; however her slowness in getting around was a problem especially with incontinence. She will require assistance on outings. [See also physical therapy note].

H. Continence

Mrs. M. is continent of bowel. She easily becomes constipated leading to fecal impaction and has had megacolon in the past. Her bowel pattern is daily in the morning with recurrent constipation 3 times a week (constipation diagnosed by presence of fecal smearing, gas, and abdominal pain). She has occasional urinary incontinence (4 times in the last seven days) when she could not get to the bathroom on time (urgency). A urinalysis was done showing greater than 30 WBCs. Due to symptoms of UTI and elevated WBCs, a C&S was ordered.

I. Disease Diagnoses

Mrs. M. has the following diagnoses: CVA in 1997 requiring extensive rehabilitation; anterior wall MI in 1988; CHF related to damage from her MI; arteriosclerotic heart disease (ASHD); osteoarthritis and rheumatoid arthritis; GI bleed and ulcer related to steroid and NSAID use; hypothyroidism for 10 years; pneumonia twice in the past 6 months; depression diagnosed post CVA 1997.

J. Health Conditions

Mrs. M has difficulty with joint pain and stiffness in the early am which resolves after her daily dose of Celebrex and movement. She has difficulty moving her fingers in the left am. Her grip is weakened, so she uses a large handle knife, and buttonhook. She describes this pain as a 6 on a scale of 1 to 10, on a daily basis. She had 2 episodes of pneumonia this past winter, which has concerned her daughter. Lung sounds on admission were diminished but clear. She sleeps at a 45-degree angle due to orthopnea. Mrs. M is afebrile. Her vital signs on admission were oral temp 97.6; apical pulse 68 and irregular; RR 18 even and unlabored at rest; and BP 138/78. She has a grade III systolic murmur, no jugular venous distention, and 2+ pitting edema. She wears bilateral lower extremity Jobst stockings for edema. Her abdomen is soft with active bowel sounds in all 4 quadrants. No complaints of nausea or recent episodes of vomiting. No history of drinking alcohol or smoking cigarettes.

K. Oral/Nutrition Status

The staff noted that Mrs. M was choking on fluids when drinking at meals. A speech therapy consult was ordered to rule out aspiration problems. A bedside swallow exam was performed and showed possible aspiration with thin liquids only. Speech therapy recommended drinking only when sitting at 90 degrees with chin tucked and no straws. Her weight is 145 pounds and she is 70 inches tall. In the past year she has lost 85 pounds. Her daughter reports that, although the weight loss has slowed, Mrs. M has had a 15-pound weight loss in the past two months. She is on a 2 GM sodium therapeutic diet. She does not always eat well, leaving 25% of the food in 2 out of 3 meals. She enjoys snacks throughout the day. At home, her daughter supplemented her diet with Carnation Instant Breakfast, increased protein intake to help with her skin, increased fruit for fiber, and gave her 6 small meals daily. She feeds herself independently using large handled utensils, but requires staff assist at meals to cut meat and to orient for food location. OT has recommended a dycem plate and rocker knife to use with meals.

[See also dietitian note].

L. Oral/Dental Status

Mrs. M has her own teeth and denied oral pain or discomfort. She last saw her dentist 6 months ago.

M. Skin Condition

Mrs. M's skin is intact. She has thin skin that tears easily related to steroid use and has healed skin tears. There are healing bruises associated with past falls. Her Braden Scale indicates that she has no impairment with sensory perception; she is able to respond appropriately and can voice discomfort. She does have slight impaired sensory impairment due to CVA (score 3). She occasionally has incontinence (score 3). She is able to ambulate independently with her walker for short distances and does so frequently throughout the day (score 3). She is able to move in bed independently (score 3). Her nutritional intake is adequate although she does have a history of significant weight loss (score 3). She occasionally slides down in her chair or does not completely raise herself up to move. This causes some skin shear (score 2). Mrs. M's total Braden score is 17 out of 23 total points possible. A score of 18 or less in people over 75 years of age indicates the resident is at risk for skin breakdown. At present she has no ulcers related to pressure or circulation. No other skin problems are noted with the exception of the bruises. A pressure relieving device will be used for her wheel chair, and lotion will be applied to keep her skin moist.

N. Activity Pursuit Patterns

Mrs. M prefers to be awakened an hour before breakfast (0500) so she can brush her teeth, comb her hair and get dressed. She has difficulty moving in the morning due to arthritis so she would prefer to bathe in the evenings. A whirlpool bath is used. She has a very firm dislike of showers. It “messes up her hair.” She does tend to sleep more than an hour each afternoon in her chair. She has not attended many formal activities at this time but prefers to rest in her room and listen to her books.

O. Medications

Lanoxin 0.25 mg daily, Prilosec 20mg daily, Celebrex 200mg daily, Calan 80mg TID, Prednisone 5mg daily, Synthroid 0.1mg daily, Bumex 1mg daily, Prozac 20mg daily, Nitroglycerine 0.4mg SL as needed for chest pain (she has difficulty with hypotension after NTG [last used 6/12/06], Pericolace 100mg BID, and Metamucil 1 tbsp every am prior to breakfast. All medications except NTG are oral (PO).

P. Special Treatments and Procedures

Restorative aide for therapeutic exercise plan 5 times per week. This is being overseen by therapy department.

Q. Discharge Potential and Overall Status

At this time it is not anticipated that Mrs. M will be discharged to return home with her daughter. Her overall status has deteriorated in the last 90 days. New onset of incontinence and falls has been the most significant change.

W. Immunizations

Mrs. M had her influenza vaccine immunization November 2006, at her private physician’s office. Mrs. M has also received the pneumococcal vaccine in 2002, also at her private physician’s office.

NOTE: There are separate physician’s orders for lab, DNR, speech therapy evaluation, physical therapy evaluation and therapeutic exercise program.

Speech Therapy Initial Evaluation

Date: January 13, 2007

Request to evaluate swallowing. History of arthritis and CVA with residual left hemiparesis, CHF, ASHD, macular degeneration, deafness and recent frequent falls at home. Has also had pneumonia twice in the last 6 months.

Discussed with nursing who has noted resident is choking on all thin liquids with all meals. No problems noted with solids. Resident is able to swallow her pills whole but then chokes on the liquid. Family has also noted problems with choking prior to admission. Resident admits to having some difficulty with liquids but denies it interferes with her meal.

Bedside swallow evaluation done. Speech is clear. No wetness noted to voice quality. Resident given applesauce and was able to swallow without difficulty, with no obvious choking or change in vocal quality. Given tsp of thin liquid. Immediate coughing noted and wetness noted in vocal quality. Repeated thin liquid swallow using a chin tuck. Resident was able to swallow without coughing or change in vocal quality. Resident did repeated demonstration of using chin tuck method successfully. Discussed with daughter and resident proposed plan and recommendations, which was agreed upon. At end of evaluation nursing was requested to auscultate lungs, which are clear at this time. Nursing made aware of recommendations. Physician made aware and orders noted.

Plan/Recommendations

1. Resident is to sit up at 90 degrees for all meals and whenever drinking fluids.
2. Resident is to sit up in chair for at least 30 minutes after each meal
3. Resident is to use chin tuck method of swallowing
4. No straws are to be used
5. Nursing to monitor lung sounds
6. Formal modified barium swallow if problems continue

Signature/Title: Ima Talk, ST

Physical Therapy Initial Evaluation

Date: January 14, 2007

Request to evaluate for strengthening, endurance, and balance. History of arthritis and CVA with residual left hemiparesis, CHF, ASHD, macular degeneration, deafness and recent frequent falls at home.

Currently, Mrs. M is able to move from supine to sit independently and from sit to stand independently with walker for balance. Transfers from bed and toilet are independent except when fatigued, then requires limited assistance of 1 person. Ambulates 20-30 feet with walker independently over even surfaces, fatigues easily and then requires limited assist of 1 person. Endurance is fair. When fatigued, uses a W/C for mobility. Mrs. M is independent with self-propelling W/C over even surfaces for short distances. Left lower extremity has 20 degrees loss of extension noted at knee. Left upper extremity has 15 degrees loss of range of motion at shoulder and elbow; otherwise range of motion is within normal limits.

- Plan:**
1. Restorative exercise program to increase strength, balance and endurance
 2. Restorative aide 5 times per week for listed activities:
 - Passive and active ROM of LUE and LLE daily
 - Leg lifts bilateral LE 5 reps for 3 sets will increase to 4 sets over 4 weeks
 - Ambulate from room to dining room 3 times per day-will increase by 10 feet weekly over the next 4 weeks.

Signature/Title: Tim Foot, PT

Nutritional Assessment

Assessment Date: 1/14/07

Resident Name: Mrs. M **Admit Date:** 1/12/07 **Age:** 90

HT/Wt: 5'10" and 145lbs **IBW:** 150 +/- 10 lb **Usual Body Wt:** 230lbs

Current Diet Order: 2 gm Na+ **Food Allergies:** None

Resident History: Significant medical dx include S/P CVA with L-sided weakness; CHF with diuretic use; constipation, arthritis, depression. History of pneumonia. Recent history of 15 lb weight loss, with overall 85 lb weight loss in past 12 months. Unknown cause, daughter states that her mother lost interest in eating when the Dr ordered diet restriction of 2 gm Na diet. Daughter had started offering several small meals at home prior to nursing home admission and thought this was helping her mother eat better. Mrs. M has been leaving > 25% of her meals since admission. Recent problem noted with choking on fluids at meals. Speech Therapy eval performed and made recommendations for staff for fluid intake.

Skin Condition: No pressure ulcers, skin tear present

Significant Lab: Albumin 3.0

Eating Assistance: Able to feed self with staff assist of cutting meat and opening cartons due to arthritis hx. OT recommendation to use dycem plate, large handle fork, and rocker knife and to orient food to clock face due to visual deficits. ST recommendation to drink only when sitting up at 90 degrees with chin tucked, no straws.

Dietary	Likes	Dislikes
Beverages:	Coffee and OJ in am Iced tea w/ lunch and dinner	Prune juice, plain milk, cranberry juice
Meat	Fried chicken, bacon, stew, roast, Pork chops, sausage	Baked fish, tuna, lunch meat
Bread/Cereal	Corn flakes, white toast, rolls, biscuits	Oatmeal, bran cereals
Vegetables	Egg salad, corn, potatoes, carrots	Peas, cucumbers, beans, cabbage
Fruit	All fresh fruit	Applesauce
Desserts/Snacks	Carnation Instant Breakfast, cookies Chocolate cake, pies	Pudding, jello

Recommendations: Recommend 5 small meals daily to encourage maximum intake. Will discuss with physician potential to modify diet order to 4 gm Na to increase consumption and to offer CIB @ 2 pm and HS daily. Also encourage fluid intake of 1500-2000cc of decaffeinated beverages to minimize risk of dehydration due to diuretic use. Will request albumin be rechecked monthly x 2. High fiber foods encouraged consistent with likes due to constipation.

Nutritional Goals: 1) Maintain current body weight of 145 up to 160 lbs (consistent w/ IBW)
2) Maintain adequate hydration without compromising cardiac status
3) Improve albumin level to 3.5 g/dl next 90 days

Signature/Title: Eata Weird, RD

Mrs. M Case Study
Interdisciplinary Notes
Sample Entries

- 1/14/07 OT Screen-Mrs. M screened for ADL assistance due to history of CVA with left-sided residual. She is unable to independently button her clothing and could benefit from a large handled buttonhook to use with her right hand. Mrs. M is independent during meal times except has difficulty manipulating utensils and she requires set up assist due to CVA limitations and vision deficit. Staff can provide assist with orienting to food location on her plate and with set up specifically cutting meat and opening cartons. OT to provide dycem plate, large handle fork, and rocker knife for additional support.....S. Jones, OTR
- 1/15/07 Dysem plate, large handle fork, and rocker knife available in dining room for Mrs. M. Staff aware of where to locate. Mrs. M understands purpose of items and able to use without difficulty. Large-handled buttonhook available in room. Mrs. M demonstrated proper use and has requested this be left in her closet along with her personal clothing. Nursing staff and daughter aware.M. Smith, COTA
- 1/15/07 Speech therapy initial eval completed 1/13/2005. Monitored Mrs. M. at lunch, no swallowing difficulties noted. Mrs. M was consistently performing chin tuck without cueing. Checked with nursing and it was reported that lung sounds remain clear. Will monitor on a prn basis.Ima Talk, ST
- 1/19/07 Nutritional assessment completed 1/14/02. Intake is consistently 75% daily with 100% fluid consumption. Physician's orders received for nutritional recommendations. Mrs. M states feeling satisfied with diet and snacks offered. Has requested that cold cereal be available some nights; cereal and fresh milk available in dining room refrigerator. Eata Weird, RD
- 1/20/07 Activities note- Mrs. M has not been involved with group activities since she has not been feeling well. She has enjoyed spending time in her room listening to books on tape. Mrs. M is interested in going on trips outside of the facility once she is feeling better but is worried about being incontinent. She wants to attend her community church, which her daughter said she could facilitate.....R. Gaye, AD
- 1/21/07 Social Service note-Mrs. M is feeling much better, both physically and emotionally and would like to plan to go out of the facility to church next Sunday. She is planning to attend group activities this afternoon. Talked with nursing about incontinence concerns on outings and Mrs. M's plans to attend church next Sunday with her daughter. Nursing will offer toileting immediately before outings. Mrs. M and her daughter are both aware of the plan.....J. Social, BSW

Mrs. M
Sample Nurse Notes for Temporary Change in Status

- 1/18/07 2330 Mrs. M confused, restless, states seeing her dead husband. Attempted to reassure but unsuccessful. Multiple attempts to get out of bed without assist. Pulse ox at 85% on room air, vital signs stable. Head of bed was elevated at 45 degrees. Brought to nurse's station and placed in a wheel chair with a lap buddy and nursing oversight.....N. Nurse, LPN
- 1/19/07 0100 No longer agitated, returned to bed w/ staff assist.....N. Nurse, LPN
- 1/19/07 0730 Mrs. M is oriented x 3 this am, remembers feeling restless last night when lying in bed. Does state feeling tired and having trouble getting to the BR on time. Vital signs stable, pulse ox 92% on room air at rest. Crackles noted in the RLL, diminished but clear throughout other lung fields. Crackles not previously noted. 3 lbs wt gain from admission wt. Also noted increased incont w/ urgency which Mrs. M stated is a change.....S. Smith RN
- 1/19/07 0800 Daughter notified of confusion through the night w/ hallucinations of seeing dead husband. She stated this is new change for her mother. Discussed changes with breath sounds and increased urinary urgency. Informed daughter that Dr would be called this am.....S. Smith RN
- 1/19/07 0830 Dr notified. Ordered CXR, CBC, UA w/C&S....S. Smith, RN
- 1/19/07 1500 Talked w/ staff about care for recent condition change, see plan of care. S. Smith RN
- 1/20/07 0800 Orders for increase in diuretic and f/u lab; urine C&S still pending...S. Smith RN
- 1/20/07 1400 States feeling some better today, breath sounds w/ faint crackles RLL, vital signs stable. Ambulating 10 – 15 ft in the hall w/walker but does fatigue easily. Mrs. M states urinary urgency is unchanged and requested to rest in room most of day. Daughter here and states that she feels her mother is feeling some better today.....S. Smith RN
- 1/21/07 1100 Antibiotic order received for new UTI. Vital signs remain stable, urinary urgency remains a problem and is exacerbated by increased diuretic but is managed with staff assist to the toilet at routine intervals. No further episodes of agitation or confusion noted since 1/18/02. AM wt has returned to baseline, breath sounds remain diminished but clear through out, LE edema 1+. Mrs. M states feeling some better, but doesn't want to get too far from the BR. Daughter notified of lab findings and Dr. orders.....S. Smith RN

Mrs. M Initial Case Study RAP Documentation

RAP Summary Note: #1 Delirium/#18 Physical Restraint

Date: 1/20/07

See Nurses notes 1/18-1/20/07

MDS items: #1 Delirium Indicators of delirium: B5b, B5d, B5f, Change in Cognitive status: B6, Change in Mood: E3 #18 Physical Restraint: Chair prevents rising P4e,

Triggers: New onset of confusion at night with hallucinations and use of lap buddy x1 to prevent getting up without assistance.

Diagnoses and Conditions: History of CVA and post CVA depression in 1997. History of MI, CHF and ASHD. 3 pound weight gain since admission, with changes in lung sounds. Abnormal UA with C&S pending

Medications: No new medications since admission. Is on several meds which could cause delirium but have been on them several years without problems.

Psychosocial: Mrs. M has recently been admitted to the nursing home, so her surroundings are new and unfamiliar. Daughter states confusion onset has been since admission and was not noted at home. Mrs. M has a history of depression and is currently on Prozac. During the night of acute confusion a lap buddy could have increased her confusion.

Sensory Losses: Mrs. M has both visual and hearing deficits. Hearing aids have been tried in the past but were found not to be beneficial. Wears glasses to aid in her vision. See vision and Communication RAP

Summary: Mrs. M has had a one-time episode of confusion at night with the subsequent use of a lap buddy. Recent medical issues have been noted that may be the cause of the delirium. Lab tests are pending on a urine C/S. Further evaluation is being done in regards to possible CHF. Decision to proceed with care plan—Yes, will care plan focusing on potential causes of delirium (UTI, CHF, visual/hearing deficits, etc.)

RAP Summary Note: #2 Cognitive Loss/Dementia

Date: 1/20/07

MDS items: Ability to understand others: C6,

Mrs. M triggered for cognitive loss/dementia due to her problem understanding others related to her hearing deficit.

1. Does resident fluctuate in their cognitive status	No
2. Has there been recent changes in the resident's cognitive function? HISTORY OF CVA BUT NO CHANGES IN COGNITIVE FUNCTION POST CVA	No
3. Does the resident have a diagnosis of mental retardation, Alzheimer's disease, and other Adult-Onset Dementias	No
4. Have the resident's cognitive skills declined prior to the initiation of a behavioral control program (psychotropic drugs, or physical restraints)	No
5. Is decline due to the treatment program (e.g. drug toxicity or negative reaction to physical restraints)	No
6. Is the other medical issues which may impact cognitive function? HISTORY OF CONGESTIVE HEART FAILURE,	Yes
7. Is there any emotional and or environmental factors play a key role? RESIDENT RECENTLY ADMITTED TO NURSING HOME AFTER LIVING WITH HER DAUGHTER	Yes
8. Is the resident showing signs of failure to Thrive?	No
9. Is the resident dependent in ADL's?	No
10. Could the resident become more independent with adaptations? SEE PHYSICAL THERAPY EVAL DATED 1/14/2005 AND OCCUPATIONAL THERAPY SCREEN ON 1/14/05	Yes
11. Does the perceptual difficulties related to visual difficulties? HAS HISTORY OF MACULAR DEGENERATION. WEARS GLASSES WHICH HELPS HER TO ADAPT.	Yes
12. Is the resident willing able to engage in meaningful communication?	Yes
13. Any medications, which may cause a cognitive decline? IS ON AN ANTI-DEPRESSANT AND CARDIAC MEDS BUT NO CHANGES HAVE BEEN MADE RECENTLY	Yes
14. Can resident make decisions in regards to activities of daily living?	Yes
15. Is resident involved in the life of the facility? SEE ACTIVITIES NOTE DATED 1/20/05.	No

Comments: Mrs. M triggered for cognitive loss due to her inability to always understand others due to hearing loss. Hearing aids have been found not to be useful.

Decision to proceed with care plan: No.

RAP Summary Note: #3 Visual Function/#4 Communication

Date: 1/20/07

MDS items: Vision Impaired: D1, Hearing, C1, Ability to understand others: C6

Mrs. M triggered for these RAP areas due to sensory deficits, resulting in highly impaired vision and hearing. Mrs. M has a diagnosis of macular degeneration and is considered legally blind. She wears glasses during waking hours to maximize her vision, but is unable to read and can only differentiate light, dark, and shapes. Now that she has adapted to her new surroundings she is able to get about the facility independently. Mrs. M also has a hearing deficit in her right ear that a hearing aid does not help. She is able to hear if speech is directed towards her left ear.

Decision to proceed with care plan—Yes

RAP Summary Note: #5 ADLs/#11 Falls

Date: 1/21/07

MDS items: #5 ADL's Physical Functioning and Structural Problems: Transfer: G1bA, Walk in room: G1cA, Walk in corridor: G1dA, Locomotion on unit: G1eA, Locomotion off unit: G1fA, Dressing G1gA, Eating: G1hA, Toilet use: G1iA, Bathing: G2aA,
/#11 Falls: Fell in past 30 Days, J4a, Fell in past 31-180 days J4b, Antidepressants: O4c

See PT eval 1/14/07; OT progress note 1/14, 1/15/07; and Nutritional assessment 1/14/07
Vision/Communication RAP and Urinary incontinence RAP

Mrs. M triggered for the above RAPs due to her need for limited assistance with ADLs and a recent history of falling at home (x 4 in the past 6 months). Recommendations for Mrs. M ADL status have been addressed by PT and OT.

In addition to a recent history of falls, Mrs. M is at fall risk due to possible medication side effects, urinary incontinence; weakness requiring limited staff assist at times of fatigue, and sensory deficits. Mrs. M's daughter is uncertain of why she might have fallen at home, except that she was trying to get to the bathroom at night. No falls have occurred since admission although there was one episode of restlessness with attempts to get out of bed unassisted [See Delirium RAP]. Medications that contribute to fall risk include Prozac, Bumex, Calan, NTG (PRN) and Digoxin. Current Orthostatic BP checks have been negative. Pharmacy review is scheduled on 1/28/05; will discuss fall risk and determine further recommendations at that time. Urinary incontinence is related to urgency secondary to diuretics and is likely exacerbated by recent UTI. Mrs. M is on antibiotics for UTI..

Decision to proceed with care plan—Yes, to alert staff to multiple risks for falls, and assistance with ADL's

RAP Summary Note: #6 Urinary Incontinence

Date: 1/21/07

MDS items: Continence in last 14 days: Bladder continence H1b

See Rehab RAP

Mrs. M triggered for this RAP due to urinary incontinence that was present at home; this became problematic for her daughter to manage, resulting in her admission. Recently urinary incontinence has worsened due to UTI and an increase in her diuretic for CHF management. Mrs. M is able to ambulate to the BR w/ walker; however she does require limited assistance of staff at times. She is able to call for assistance, but due to urgency can only hold her urine for about 5 minutes. Urgency is greater in the morning after Bumex administration. Mrs. M has not been willing to consider using a bedside commode; she strongly prefers to use the BR. Mrs. M is currently on an antibiotic. Urine C&S has been done; additional physician follow up is pending.

Decision to proceed with care plan--Yes

RAP Summary Note: #12 Nutritional Status/#14 Dehydration/Fluid Maintenance

Date: 1/19/07

MDS items: #12 Nutritional Status Oral/Nutritional Status: K3a, Leaves 25% or more food uneaten, K4c, Therapeutic diet, K5e, **#14 Dehydration/Fluid Maintenance:** UTI: I2j, Taking diuretic: O4c

Mrs. M. triggered for nutritional issues due to not eating all that is offered. Daughter relates the change in eating habits since Mrs. M was placed on 2-gram sodium diet. See nutritional assessment dated 1/14/07, and dietary progress note dated 1/19/05. Mrs. M triggers for dehydration/fluid maintenance issues that are related to recent UTI and patient is on long term diuretics. Mrs. M. is has a urine culture pending. Mrs. M. has been taking diuretics prior to admission, which are necessary to her history of CHF.

Proceed to care plan: yes

**RAP Summary Note: #7 Psychosocial/#8 Mood state/#10 Activities/
17 Psychotropic Drugs**

Date 1/19/07

MDS items: #7 Psychosocial: Establishes own goals F1d, Strong identification with past: F3a; **#8 Mood state:** Insomnia, changes in sleep pattern: E1k, Crying, tearfulness: E1m, Repetitive, physical movements: E1n, Mood persistence: E2; **#10 Activities:** Prefers changes in daily routines: N5a, Awake or most of the time in the morning N1a, **# 17 Psychotropic Drugs:** Must first have triggered for Psychotropic drug: Antidepressant: O4b Repetitive physical movement: E1n, Unsteady gait: J1n, Fell in last 30 days: J4a, Fell in past 31-180 days J4b, Swallowing problem: K1b, Periods of altered perception or awareness of surroundings: B5b

Mrs. M triggered for these RAP areas due to her strengths in setting own goals, strong relationship with past. Other triggers show potential problems with the episodes of tearfulness, change in sleep pattern, activities involvement and use of antidepressant for depression diagnosis. Mrs. M confirms missing her family and feeling of concern about visiting her daughter's home since she has been incontinent; but states that she is feeling better now that she is becoming acquainted at the nursing home. Her daughter states that the tearfulness has improved in the past few days.

The antidepressants may also have drug related problems, which were also triggered. The repetitive physical movements was related to the one episode of restlessness captured during a night shift, when Mrs. M. was not feeling well (See nursing note 1-8-07),

Mrs. M has a history of depression secondary to CVA and has taken Prozac since 1997. The swallowing problems and falls which were also triggered are not felt to be related to the Prozac. Her daughter stated that Mrs. M had done well while living at home in regard to mood, however since admission to the nursing home her daughter has noted occasional episodes of tearfulness. Her daughter states that the tearfulness has improved in the past few days.

Mrs. M has not been involved in group activities or outings outside the facility since she has not been feeling well, but does state a desire to do so; she is however, concerned about her

incontinence. She very much wants to attend her community church, but again is concerned about incontinence. The plan is to facilitate outings and group activities once she is feeling better. Presently, Mrs. M is enjoying books on tape and enjoys her roommate's company. Her daughter is very involved in her care and visits or calls daily. Her daughter stated that she would facilitate getting her mother to church once she feels better.

Decision to proceed with care plan—yes

CARE PLAN ISSUES NOT COVERED UNDER A RAP

Pressure Ulcers: Even though it did not trigger according to the Braden Scale Mrs. M is at risk for skin breakdown. In the care plan would be interventions that should address the areas of concern, which would be incontinence, weight loss, and positioning in the chair.

An additional item, which does not have a RAP, is pain. Mrs. M does have arthritis and moves slower in the morning. Interventions in the care plan should also address this. Pain should be monitored to ensure that the current regime keeps her comfortable. A PRN pain medication order may be necessary if her pain increases.

Mrs. M. Care Plan

Mrs. M recently moved to the nursing home. She had been living with her daughter, Susan who now visits daily. She has 3 other children who live out of state. Mrs. M had a stroke several years ago which affected her ability to be independent. She was a homemaker and graduated from high school. English is her first language but will revert to German if she becomes upset.

Date	Problem	Goal	Interventions	Discipline	Review
1/18	Confusion esp. at night	Will not have another episode of confusion at night during next 7 days	<ol style="list-style-type: none"> 1. Check hourly between 9PM and 5 AM. If restless: check for need to toilet, check if hungry, check for pain, alert nurse to check O2 sats and get set of VS 2. Offer reassurance if scared or lonely 3. Assist up in chair and position at nurse's station 4. Elevate head of bed to 45 degrees 5. Leave night light on in room 6. Pt. is HOH, be sure you have her attention and not frighten her 	RN, CNA	
1/12	Requires help with mobility and ADL's	<p>Increase ambulation distance to 40 feet with walker and SBA of 1 by 3/1/05</p> <p>Maintain ability to dress self with minimal assist through 3/1/05</p>	<ol style="list-style-type: none"> 1. Walk to dine: Lunch and dinner. 2. Use wheel chair for breakfast 3. Ambulates with w/walker and SBA to min assist. 4. May use wheel chair if tires quickly 5. Alternating leg lifts 5 repetitions each leg-3 sets daily 6. Passive and active ROM to LUE and LLE every day 7. Adaptive equipment for dressing: Large handled buttonhook. Be sure Mrs. M. can reach it during dressing. 8. Prefers a tub bath in the evening 9. Adaptive equipment for eating: 	RN, CNA	

			<p>Dycem for under her plate, large handled rocker knife for cutting meat, foam handles for fork and spoon. Keep in tote bag</p> <ol style="list-style-type: none"> 10. Evaluate for need for pain medication. Alert nurse if Mrs. M complains of pain. 11. Promote and encourage independence with ADL's 12. Allow time as needed for Mrs. M to perform her ADL's. 13. Break up tasks into shorter segments to conserve strength. 		
1/12	History of falls	<p>Reduce number of falls to less than one a month by 3/1/05. Minimize risk of injury related to falls through 3/1/05</p>	<ol style="list-style-type: none"> 1. Be alert for fatigue with ADL's. Offered assistance if necessary. 2. Ambulates with SBA to min assist with w/walker. 3. Uses a night light at bedtime 4. Answer call light immediately due to urinary urgency 5. Keep bed in low position 6. Consider bed alarm if Mrs. M continues to have periods of confusion at night. 7. Be sure Mrs. M wears glasses when awake. Glasses should be clean 8. Is HOH but can hear better is spoken directly into left ear. 9. Encourage use of non-skid shoes 	All	

Date	Problem	Goal	Interventions	Discipline	Review
1/12	I am new to the nursing home	<p>I will not have any crying spells through 3/1/05.</p> <p>I will attend an activity at least once a week.</p> <p>I will go out with my daughter at least every other week.</p>	<ol style="list-style-type: none"> 1. Treat me as an adult with major changes in my life. I am not use to living with so many people. 2. When you have time, please sit and visit with me, I am use to my daughter being around and now I get lonely. 3. If I cry just be with me. I don't expect a miracle but just someone to hold my hand. 4. Let me know what activities are happening in the building so that I can make my own choice to attend. 5. I enjoy listening to books in the afternoon, please honor this time and not interrupt me. 6. I am afraid I will wet my pants, please answer my call light promptly and allow me time to go prior to an activity. 7. I enjoy time with my daughter and want to go to church with her when it can be arranged. 8. I take an antidepressant and want to continue it because I know it helps me. If you notice I am crying more, and not attending activities please let my physician know. I may need a medication adjustment. 	All	

1/12	I don't have much warning before knowing I have to urinate.	I won't wet my pants more then once a day by the end of the month.	<ol style="list-style-type: none"> 1. Please take me to the bathroom as soon as I wake up, before meals and at bedtime. 2. I will need to go to the bathroom 30 minutes after taking my pills in the morning. 3. Be sure to allow time before activities that I can go to the bathroom. 4. Please be sure my call light is where I can see and reach it 5. Please answer my call light promptly. 6. If I do have an accident don't scold me, I am already embarrassed. 	All	
1/12	I don't have much appetite and the food doesn't taste good	I will not lose any more weight by March I will feed myself with adaptive equipment.	<ol style="list-style-type: none"> 1. I can't much at a time so I would rather eat small frequent meals. 2. My daughter made me Carnation Instant breakfast for between meals that I enjoyed and would like to continue. 3. I need to eat fiber in my diet so that I don't get constipated. Please offer me grapes, oranges and peaches whenever possible. 4. At night I get hungry I would like a bowl of cold cereal. 5. I can't see very well so please let me know what is on my plate by using a clock. 6. I have arthritis and have had a stroke. It makes it hard to feed myself. I need large handles 	Dietary Nursing Activities	

			<p>utensils and my special knife. I also use something special to keep my plate from sliding away from me.</p> <p>7. Weigh me weekly to be sure that I am not holding too much fluid meaning my heart has to work harder.</p> <p>8. I have trouble swallowing and must sit up straight in my chair when I eat. I also tuck my chin to make it safer to swallow and please don't offer me a straw.</p> <p>9. The nurses should listen to lungs daily to be sure they stay clear. If they are not clear my doctor should be called.</p>		
1/12	I don't have problems with my skin	I don't want to have problems with my skin	<p>1. Please be sure I am offered fluids. Pour them in a cup, as the pitcher is too heavy for me.</p> <p>2. I can turn myself but may need to be reminded.</p> <p>3. I don't want to have wet skin so please follow me care plan to keep me dry.</p> <p>4. If I do wet myself please clean me up thoroughly and dry my skin well.</p> <p>5. I like to wear long sleeve blouse to protect my skin</p> <p>6. During showers be sure I do not have any redden areas where I can not see.</p>	Dietary Nursing	

1/12	I do not like to be in pain	My pain will be under control and less than a 6 on any given day.	<ol style="list-style-type: none"> 1. If I say I am in pain I am. 2. Please be sure that I get my regular meds on time 3. I am stiff in the morning so keep it in mind as I am getting dressed and ready for the day. It takes me longer to do things then. 4. If I need something extra pain please get to me as soon as possible. 5. I listen to my books that help me to cope with my pain. Please allow me the privacy to listen to my books. 6. If my pain is really bad a warm bath or a gentle back rub sometimes will help. 	Nursing	
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