

Resident Assessment Instrument

Case Study Part II

Significant Change in Status/ Medicare Readmission

**REVISED
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Resident Assessment Instrument Case Study Part II-Significant Change in Status

Incident

On December 15, 2005, Mrs. M was found on the floor in her room at 3:30 AM by the staff. When the CNA asked Mrs. M what happened, she stated “I was trying to go to the bathroom and I fell”. The night shift supervisor was summoned and completed a post fall assessment.

Assessment Findings: Mrs. M’s major complaint is extreme pain, level 8 on a scale of 1-10, in the left hip area. Upon examination of her left hip, it is noted that there is external rotation and extreme pain on change of position. In addition, there appears to be some shortening of the left leg. Her vital signs were Temp – 98.9, Pulse – 96, Respiration’s – 28, and B/P – 136/90. Pupils are equal and reactive. She is able to move all other joints, within her normal range of motion.. She has a skin tear on her right forearm. Mrs. M was put into bed, the left leg was immobilized, and the skin tear was cleansed and dressed. Mrs. M’s physician was called and given a report of the incident. He gave an order to transfer Mrs. M by ambulance to the hospital for evaluation and possible admission. Mrs. M’s daughter was notified that her mother had fallen and was being transferred to the hospital. Later that day, Mrs. M’s daughter notified the facility that her mother had left hip surgery and is doing well. It is anticipated the Mrs. M will return to the facility after her acute stay.

Discharge Tracking Information

Mrs. M was admitted to the hospital on December 15, 2005. It is anticipated that she will return to the facility after her hospital stay.

Reentry To The Facility

On December 20, 2005, Mrs. M returned to the facility. Mrs. M had left hip surgery, Open Reduction Internal Fixation (ORIF) on December 15, 2005. She meets the skilled level of care and criteria for Medicare Part A coverage and will be placed in a Medicare bed. She will receive skilled rehabilitation on a daily basis. Her medical insurance includes Medicare Part A and B and supplemental medical coverage. Her daughter has signed her up for Medicare D coverage.

Physical Functioning

Mrs. M’s weight bearing status is “toe touch” (TTWB) on the left leg along with limited ROM. She is not able to raise her left leg but can raise her right leg without difficulty. Mrs. M has residual left sided weakness from her past CVA. Her left arm is weaker than her right arm but she is able to use the left arm to help support ambulating with a walker. She is not able to use her left arm to touch the back of her head. Her left leg is also weaker than her right but this is only problematic when she is tired or ill. The test for balance was not

attempted because Mrs. M is unable to stand by herself. Due to her CHF and therapy schedule she becomes fatigued and unsteady, thus she needs the staff to transport her by wheel chair to all activities, meals, and therapy. Weight bearing assist of one person is required for all transfers but she can self propel in a W/C a short distance in her room after transfer assistance. Mrs. M receives supervision and verbal curing for using a trapeze for pulling herself up in bed. On two occasions when her arms were fatigued, she received heavier physical assistance of one person. She is able to help turn herself in bed with the assistance of side rails and one person to physically position her left leg. Mrs. M is able to perform upper extremity self care activity and tasks of daily living but she is very slow. She requires minimal assistance of one person with upper extremity dressing daily. She is able to button her clothing using a large handled buttonhook. She requires physical assistance of one person to assist her with lower extremity dressing daily. She requires weight-bearing assistance of one person with transfers in and out of the bathtub. She receives weight-bearing assistance of one person to transfer on/off the toilet and requires only standby assistance with hygiene (e.g., being handed toilet tissue). Mrs. M has not walked in the hall since her return from the hospital. Mrs. M has fallen 2 times in the last 14 days and 4 times in the last six months. Her last fall was five days ago and occurred when she was attempting to go to the bathroom during the night.

Diagnoses

Mrs. M has the following diagnoses:

- Fractured left hip
- 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
- Depression diagnosed post CVA 1997

Current Condition

Mrs. M is alert and oriented. Both long and short-term memory remain intact. She is experiencing left hip pain and pain at the incision site. She describes the hip pain as a 7 on a scale of 1 to 10. Tylenol every 4 hours as needed relieves the pain. In addition, she has difficulty with joint pain and stiffness in the early A.M., which resolves after her daily dose of Relafan and movement. She sleeps at a 45-degree angle due to orthopnea. Mrs. M is afebrile, at present but since her surgery she has run a late afternoon fever. Her vital signs on readmission were: Temperature – 98.2 orally, Pulse 70 and irregular, RR 20 even and unlabored, and B/P 142/80. She has a grade III systolic murmur, no jugular venous distention and 2+ pitting pedal 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. The left hip incision site is dry with no signs or symptoms of infection. The left lower extremity's color is pink, warm to the touch, and

pedal pulses are strong. Her weight is 135 pounds and she is 70 inches tall. In the past 6 months, her weight has remained virtually unchanged with the exception of a 5 pounds loss since her fall and hospitalization. She is on a No Added Salt therapeutic diet. She doesn't always eat well at meals, leaving 25% of the food in 2 out of 3 meals. Mrs. M states that she ate even less when she was in the hospital, "the food was awful". She receives snacks throughout the day to supplement her diet. She is independent with feeding herself after tray setup. She uses a dycem plate and rocker knife to eat her meals. Mrs. M did have an IV of D5 ½ Normal saline at 100 cc an hour for hydration initially after surgery for 3 days. It was discontinued on December 18, 2005.

Mrs. M has a healing surgical wound on the outer left thigh and healing skin tear on her right forearm. She has thin skin that tears easily related to steroids. She also has a reddened area on coccyx with the skin intact. Her left heel has an intact blister on it with the skin around it feels soft to the touch. Her Braden Scale indicates that she has no impairment with sensory perception; she is able to respond appropriately and can voice discomfort (score 3). Since the foley catheter was removed, she occasionally has incontinence several times a week (score 3). Her ability to walk is limited. She cannot bear full weight on the left leg and must be assisted into the chair or wheelchair (score 2). Mobility is limited. She makes slight changes in body or extremity position, but is unable to make significant changes independently (score 2). Her nutritional intake is good and she does have a history of recent weight loss (score 3). She occasionally slides down in her chair and doesn't always completely raise her buttocks to sit back up. This causes some skin shear (score 2). Total Braden score is 15 out of 23 total points. (A score of 18 or less in people over 75 indicates the resident is at mild risk for skin breakdown). Mrs. M is receiving PT and OT as ordered by her physician. Since therapy began the longest distance Mrs. M walked when most self-sufficient was 30 feet in 20 minutes with one-person physical assist. This occurred while walking in the parallel bars during a therapy session.

Medications

Medications as listed on the MAR:

Lanoxin 0.25 mg daily PO

Prilosec 25 mg daily PO

Relafin 1000 mg daily PO

Calan 80 mg TID PO

Prednisone 5 mg daily PO

Synthroid 0.1 mg daily PO

Bumex 1 mg daily PO

Prozac 20 mg daily PO

Nitroglycerin (NTG) 0.4 mg SL spray PRN for chest pain

Tylenol 325 mg 2 tablets every 4 hours PO PRN hip pain and 30" before therapy (received 15 times in the last 7 days)

Pericolace 100 mg BID PO

Metamucil 1 Tbsp in AM prior to breakfast PO

Treatments and Procedures

While in the hospital, Mrs. M had a foley catheter, was on I&O, received one blood transfusion on December 16, 2005, and received IV medications and IV fluids for hydration for 3 days post op. Admission orders included:

- Remove foley catheter on 12/21/05
- I&O
- Dry dressing to left hip surgical incision daily
- Elevate both heels off bed
- Duoderm to coccyx, change q 3-4 days
- Protine on day 2 and 4 (results were within normal limits)
- Hgb and Hct on day 2, then in 30 days
- Pt and OT to evaluate and treat

Therapy evaluations were completed on December 21, 2005 and treatment plans were developed to include:

- PT – 30” bid for gait training, TTWB; parallel bars progressing to walker; TTWB transfer training; therapeutic exercise; and pain assessment.
- OT – 30” daily for LE dressing; bed/WC positioning; bed mobility; and functional transfers.

Therapy minutes provided during the last 5 days:

PT evaluation	30 minutes
PT treatments	180 minutes
OT evaluation	30 minutes
OT treatments	90 minutes

Immunizations

Influenza vaccine given at the facility November 2005
Pneumococcal vaccine given at physician’s office November 2003

RUG Classification

RMX - Rehabilitation Medium/Extensive Nursing
ADL score was - 15

MEDICARE CALENDAR

RESIDENT Mrs. M	ADMIT DATE 12/20/05
HOSPITAL STAY DATES 12/15/05 – 12/20/05	MEDICARE DAYS AVAILABLE 100

1 12/20	2 12/21	3 12/22	4 12/23	5 <u>12/24</u> ARD	6 12/25/ G	7 12/26 G	8 12/27 G	9 12/28	10 12/29
<u>11</u> <u>12/30</u> ARD	12 12/31	13 1/1	14 1/2	15 1/3 G	16 1/4 G	17 1/5 G	18 1/6 G	19 1/7 G	20 1/8
1/9 21 Co-insurance starts	22 1/10	23 1/11	24 1/12	25 1/13	26 1/14	27 1/15	28 1/16	29 1/17	30 G
31 G	32 G	33 G	34 G	35	36	37	38	39	40
41	42	43	44	45	46	47	48	49	50
51	52	53	54	55	56	57	58	59	60 G
61 G	62 G	63 G	64 G	65	66	67	68	69	70
71	72	73	74	75	76	77	78	79	80
81	82	83	84	85	86	87	88	89	90 G
91 G	92 G	93 G	94 G	95	96	97	98	99	100

ASSESSMENT REFERENCE DATE WINDOWS

			ARD	COMP	RUG SCORE
5 DAY	1-5		12-24-05	12-30-05	RHC/RMX
14 DAY	11-14		12-30-05		
30 DAY	21-29				
60 DAY	50-59				
90 DAY	80-89				
Sig change	12-24-05				
OBRA INITIAL					
OBRA QTRLY					

Shaded Areas/Bolded Dates = Assessment Window
 Bolded Lines Around Box = Payment Days

G = Grace Days

Interdisciplinary Notes
(Sample Entries)

12/20/05 Significant change in status triggered due to recent Left Hip Fx secondary to a fall; ORIF performed on 12/15/05. Return to facility with admit to Medicare status this date for rehab; physician's orders include daily PT and OT. Overall functional decline noted with bed mobility, transferring, ambulation and LE ADLs; recent incontinence and increased pain are also concerns. Assessment reference date set as 12/24/05 and communicated to staff.....S. Coordinate, RN

12/21/05 Activities Note: Talked with Mrs. M re' activity needs. Her desire is to stay active with attending weekly music group and Bible study. She would like to attend the facility church service for the next few weeks since she will not be able to go out of the facility to her own church. She has also requested that her daughter do any of her personal shopping until she is "feeling stronger". Message left for her daughter. Mrs. M has also requested additional books on tape to allow her quiet time in her room to rest. Talked with nursing staff re' assisting resident to scheduled activities....R. Gaye, AD

12/22/05 Dietary Note: Mrs. M returned to the facility on 12/20/05 after a brief hospital stay at which time she lost 5 pounds, current wt 135#. Her wt had been stable the past several months even though she continued to leave 25% or more of her meals. 12/15/05 albumin of 3.5 indicates mild protein depletion, but is an overall improvement from 11/12/05 alb of 3.2. She received a transfusion of I unit PRBCs post op; Mrs. M. did have IV fluids for hydration for 3 days following her hip surgery. Will monitor to ensure she does not need additional fluids. 12/18/05 Hgb 8.3 and stable. Will recommend Fe Supp TID with follow up lab in 2-4 wks, hx of constipation will require close monitoring. Mrs. M has maintained the ability to eat independently with set up assistance and adaptive equipment. Swallowing difficulties post CVA remain a concern, but are minimized with cueing and proper positioning. She would like to continue her between meal snacks of fresh fruit, specifically grapes, oranges, and peaches. Canned fruit is suitable if fresh is not available. She prefers Carnation Instant Breakfast as a protein snack, but would like cold cereal offered occasionally. According to nursing staff, Mrs. M has an increased risk of skin breakdown so will plan to assess intake weekly and offer choices to meet her increased needs. Mrs. M is aware of her changing dietary needs and is willing to work toward improved intake to regain the few pounds she lost and to improve protein intake. She is agreeable to eating meals in the dining room.....Eata Weird, RD

12/30/05 Significant change in status MDS and RAPs completed and discussed at the care plan team meeting, resident and daughter in attendance. Care plan goals discussed and agreed upon. Functional ability improving and pain better controlled. Continue with daily PT and OT, plan to review progress in one week on 01/06/06.....S. Coordinate, RN

Physical Therapy Initial Evaluation
12/21/05

Reason for evaluation: Recent L hip fx, s/p ORIF on 12/15/05. Physician's order for 5X Wkly PT for gait training, transfer training, therapeutic exercise and pain assessment/management; TTWB status.

Baseline function: Prior to hip fx resident was able to transfer and ambulate 20-30 feet independently with rolling walker; limited endurance due to CHF hx. When fatigued, would transport via wheel chair with staff assist of one. Also, S/P CVA with L-sided weakness UE/LE.

Initial evaluation: Required mod assist of one for position change from supine to sit due to pain and leg positioning; maintained sitting balance at side of bed. Mod assist of one for pivot transfers in/out of bed using standard walker for balance and to maintain WB status. Amb 30 feet in parallel bars and required verbal cue x2 to limit WB to toe touch. Independent with W/C mobility in room only. Stated L hip pain 7/10 prior to eval, request for pre-therapy medication effectively reduced pain to 2/10.

Plan: PT for 30 min BID 5X weekly X 4 weeks for gait training; transfer training, therapeutic ex, parallel bars progressing to walker. Pain management coordinated with nursing for pre therapy medication to facilitate therapy sessions.

Occupational Therapy Initial Evaluation
12/21/05

Reason for evaluation: Recent L hip fx, s/p ORIF on 12/15/05. Physician's order for 5X wkly OT for LE dressing, bed/wc positioning, bed mobility and functional transfers.

Baseline function: Prior to hip fx, resident had CVA with L-sided weakness (1997) and hx of CHF. She has been independent with ADLs except bathing and toileting, and is slow with task completion on most days. She required min assist of one to don/doff UE garments, but can button garment front independently with the aid of a large handled button hook. Required min assist of one with daily LE dressing to don/doff Jobst stockings, but could place slacks, socks and shoes independently most days. She was independent with bed mobility; required stand by assist to min assist for safety with toileting and transferring in/out of tub.

Initial Evaluation: Required min-mod assist with bed mobility for leg positioning. Required mod assist of one with all LE dressing due to pain, limited ROM of L-hip, and WB limitation. Also required mod-max assist of one for transferring on/off toilet and in/out of bathtub. Upper extremity dressing and ADLs remain unchanged from baseline, however required staff assist with set up due to limitations with mobility.

Plan: OT 30 min daily 5X per week X 4 weeks for LE dressing, bed/WC positioning, bed mobility, and functional transfers.

Mrs. M PPS-Significant Change RAP Documentation

RAP Summary Note: #1 Delirium

Date: 12/30/05

MDS items: #1 Delirium: Change in Mood: E3

Triggers: Since readmission Mrs. M has had several episodes of crying especially during therapy and at night, when she has difficulty sleeping. She is also using the call light more frequently checking on her schedule, meal times, etc. This is a change as noted in the MDS within the last 90 days.

Diagnoses and Conditions: History of CVA and post CVA depression in 1997. History of MI, CHF and ASHD. 12/15/05 Mrs. M fell in her room resulting in a fractured hip. Was hospitalized 5 days for surgical repair

Medications: Is currently on the same medications as prior to hospitalization except for Tylenol. She is taking this for pain but it is felt that it is not contributing to the change in her mood and behavior. Is on several meds that could cause delirium but have been on them several years without problems.

Psychosocial: Mrs. M has a history of depression and is currently on Prozac. She has recently returned from the hospital after a hip fracture. This may contribute to her increase need for reassurance as seen by the frequent use of the call light.

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: Since returning from the hospital a change has been noted in Mrs. M's mood and behavior. It is felt to be related to her recent hospitalization with surgery, and fears of falling again and losing her independence. This should decrease as she improves in therapy. Will care plan initially to monitor for escalation of behaviors and to help alleviate current behaviors.

RAP Summary Note: #2 Cognitive Loss/Dementia

Date: 12/30/05

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 FELL AND WAS HOSPITALIZED FOR A HIP REPAIR	Yes
8. Is the resident showing signs of Failure to Thrive?	No
9. Is the resident dependent in ADL's? NO BUT SHE NOW REQUIRES MORE ASSISTANCE DUE TO HER RECENT SURGERY	No
10. Could the resident become more independent with adaptations? SEE PHYSICAL THERAPY EVAL DATED 12/21/05 AND OCCUAPTIONAL THERAPY SCREEN ON 12/21/05	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 12/21/05.	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. There have been no changes since her original admission

Decision to proceed with care plan—No

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

Date: 12/30/05

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. There have been no changes in either area since the original admission. See Visual Function and Communication RAP note dated 1/21/05.

Decision to proceed with care plan—Yes

RAP Summary Note: #5 ADLs/#11 Falls

Date: 12/30/05

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, Antidepressants: O4c

See PT eval 12/21/05; OT eval 12/21/05; and Dietary note dated 12/22/05

Vision/Communication RAP 1/21/05 and Urinary incontinence RAP dated 12/30/05

Mrs. M triggered for the above RAPs due to her need for limited to extensive assistance with ADLs and a recent fall resulting in a fracture. PT and OT have addressed recommendations for Mrs. M ADL status.

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 to extensive staff assist at times of fatigue, and sensory deficits. Medications that contribute to fall risk include Prozac, Bumex, Calan, NTG (PRN) and Digoxin. Pharmacy review to be done per facility protocols and determine further recommendations at that time. Urinary incontinence is related to urgency secondary to diuretics and is likely to be exacerbated by recent catheter insertion.

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: 12/30/05

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

Mrs. M triggered for this RAP due to urinary incontinence that has been a problem for her since prior to her admission at home and has continued since her original admission. During the hospitalization a catheter had been inserted but has since been removed on 12/21/05. Since the removal Mrs. M has been incontinent several times a week, which is similar to her voiding pattern prior to hospitalization. Mrs. M is unable to ambulate to the BR w/ walker due to fatigue. She requires weight bearing assistance of one person to transfer on/off the commode. 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.

Decision to proceed with care plan—Yes

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

Date: 12/30/05

MDS items: #12 Nutritional Status Oral/Nutritional Status: K3a, Leaves 25% or more food uneaten, K4c, IV fluids K5a and Therapeutic diet, K5e, **#14 Dehydration/Fluid Maintenance:** Taking diuretic: O4c

See dietary note dated 12/22/05. No change essentially original admission. See RAP note dated 1/19/05 for Nutritional Status and Dehydration/Fluid Maintenance.

Proceed to care plan—Yes

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

Date: 12/30/05

MDS items: #7 Psychosocial: Establishes own goals F1d, Strong identification with past: F3a; **#8 Mood state:** Insomnia, changes in sleep pattern: E1k, Repetitive anxious complaints/concerns E1i, Crying, tearfulness: E1m, Mood persistence: E2; **# 17 Psychotropic Drugs:** Must first have triggered for Psychotropic drug: Antidepressant: O4b, Unsteady gait: J1n, Fell in last 30 days: J4a, 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, and a 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 her depression diagnosis. Since her return from the hospital the staff has noted and increase in her crying that had resolved after her initial admission. She is also using her call light more often checking on schedules, etc.

The antidepressants may also have drug related problems, which were also triggered. She has been on Prozac for many years without any noted side effects.

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. The fall resulting in the hip fracture was at night when Mrs. M was attempting to go to the bathroom unassisted.

Mrs. M would like to remain active in the life of the facility by attending weekly music group and bible study. Once she is stronger she would like to resume going to church with her daughter. Her daughter will assist with this when appropriate. Mrs. M also enjoys books on tape and arrangements will be made to continue this service.

Decision to proceed with care plan—Yes

RAP Summary Note: #16 Pressure Ulcers

MDS items: M2a Pressure ulcer Stage 2: G1aA Bed mobility;

Mrs. M. triggered for pressure ulcers due to an intact blister on her left heel that developed during her hospital stay. Mrs. M has had no change in her cognitive stats and will be able to help protect her heel and keep the pressure off. She does have a history of edema in the lower extremities that will need to be monitored. She has been on anti-depressants for many years without problems. Will care plan to ensure pressure is reduced to that area and no further problems develop.

CARE PLAN ISSUES NOT COVERED UNDER A RAP

There is no RAP for pain, which is a problem for Mrs. M on a daily basis. Besides the recent surgery for the hip fracture Mrs. M also has arthritis and moves slower in the morning. Interventions in the care plan should address these issues. The Tylenol prn should be monitored that it is effective to allow Mrs. M to participate in therapy and be able to carry out the activities she chooses without pain hampering her. Alternatives to medication for pain control should also be explored and care planned for.

CARE PLAN

Please note that the care plan is written initially in the traditional format. After the first two problems it is then written in the "T" format, which allows the care plan to be more personalized and resident centered.

Mrs. M. Care Plan (Post Significant Change)

Date	Problem	Goal	Interventions	Discipline	Review
12/30/05	Worried and scared since readmission Crying more frequently	Decrease call light use to a max of once an hour Frequency of crying spells will be less than once a day	<ol style="list-style-type: none"> 1. Answer call light promptly 2. Stop by room to check on Mrs. M and anticipate her needs, i.e. offer fluids, take to the bathroom before she asks, etc. 3. Be sure that she gets her pain medication prior to therapy 4. Allow for rest periods between activities so that she is not over tired. 5. Provide positive feedback for all accomplishments 6. Offer toileting per facility protocol to decrease possibility of incontinence 7. Sit with her and offer reassurance when crying 	All	
12/30/05	Poor vision and hard of hearing	Will be able to move about her room and facility without difficulty. Will be able to hear and understand those around her without difficulty	<ol style="list-style-type: none"> 1. Speak distinctly and clearly and toward left ear 2. Minimize external noises or move to a quieter place when talking with Mrs. M. 3. Be sure you have her attention prior to starting to speak 4. Speak towards my left ear 5. Keep her room clear of clutter 6. Keep room lights on till bedtime then use a night light 7. Keep Mrs. M's belongings within her reach especially her water and Bible. 8. Don't rearrange her room without discussing with her first. 9. Be sure Mrs. M wears glasses when awake and that they are clean. 	All	

Date	Problem	Goal	Interventions	Discipline	Review
12/30	I fell recently and broke my hip and had to have surgery	I want to try not fall again but if I do I don't want to hurt myself very badly.	<ol style="list-style-type: none"> 1. Please know that I like to do my ADL's but right now I need more help due to the surgery and I tire very easy at this point. 2. Please help me with all my transfers. I use a walker and need at least 1 person to assist me on/off the commode 3. I would like to nap between each meal so that I don't get over tired. 4. Answer my call light promptly because I don't have much warning before needing to urinate. 5. Be sure I have on my shoes before I get up for a transfer 6. Keep my bed in low position and my call light in reach 7. I take several meds that may make me dizzy and have low BP. Please watch me for these symptoms. Encourage me to sit and stand slowly. 	All	
12/30	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 next 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	

12/30	I don't have much appetite and the food doesn't taste good	I will not lose any more weight by February I will feed myself with adaptive equipment.	<ol style="list-style-type: none"> 1. I can't eat 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 that. 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 utensils and my special knife. I also use something special to keep my plate from sliding away from me. 7. Weigh me weekly to be sure that I am not holding too much fluid meaning my heart has to work harder. 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. Please don't offer me a straw. 9. The nurses should listen to my lungs daily to be sure they stay clear. If they are not clear my doctor should be called. 	Dietary Nursing Activities	
12/30	I have a reddened heel	I want the area to get better and no further problems occur	<ol style="list-style-type: none"> 1. Please be sure I am offered fluids. Pour them in a cup, as the pitcher is too heavy for me. 2. I need help turning since my surgery so please do it at least every 2 hours when I am in bed 3. Please help me reposition at least every hour when I am in my wheelchair 4. Keep my heel up off the bed and the pressure off 	Dietary Nursing	

			<p>at all times.</p> <ol style="list-style-type: none"> 5. When I not in therapy please remove my shoe so that it doesn't make my heel worse. 6. I don't want to have wet skin so please follow my care plan to keep me dry. 7. If I do wet myself please clean me up thoroughly and dry my skin well. 8. I like to wear long sleeve blouse to protect my skin 9. During showers be sure I do not have any redden areas where I cannot see. 		
12/30	I do not like to be in pain	My pain will be under control and less then a 6 on any given day.	<ol style="list-style-type: none"> 1. If I say I am in pain I am. 2. I respond best to the verbal scale to describe my pain (Use crosswalk to obtain numeric score). 3. Please be sure that I get my regular meds on time 4. 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. 5. If I need something extra for pain please give it to me as soon as possible. 6. I listen to my books that help me to cope with my pain. Please allow me the privacy to listen to my books. 7. If my pain is really bad a warm bath or a gentle back rub sometimes will help. 8. I also have a hard time sleeping at night. Be sure I go to the bathroom and have something for pain before going to bed. 9. Take me to the bathroom and give me a drink if I am restless at night. I may need a pain med again. 	Nursing	

12/30	<p>I need help with getting around and getting dressed and undressed I want to get to where I can do as much as possible for myself again.</p>	<p>Within 6 weeks I will be able to dress myself with min assist. Within 6 weeks I will be able to walk to the bathroom in my room with min assist</p>	<ol style="list-style-type: none"> 1. Until I can walk distances please push me to therapy in my wheelchair. 2. Please help me with all my transfers 3. Adaptive equipment for dressing: Large handled buttonhook. Be sure it is out when I am getting dressed. 4. I prefer to bath in the evening. 5. Adaptive equipment for eating: Dycem for under my plate, a large handled rocker knife for cutting meat, foam handles for fork and spoon. I keep them in my tote bag on the back of my wheelchair. 6. Be sure I have my pain pills before I start my dressing 7. I like to be complimented when I have accomplished a hard task for the first time. 8. Please don't rush me I dress slowly. 9. It easier for me if I break up my activities into short periods to conserve my energy. 		
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