EPaD GEC
Clinical Skills Scenario(CSS)

Summary of Initial Patient Assessment

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Nursing Assessment

10-11-07 to 10-17-07

Ms. Florine Walker is a 76 year-old female who was admitted from the ED on 10/11/07 with Right CVA. PMH includes: hyperlipidemia, hypertension, osteoarthritis, and osteoporosis.

Neuro: left-sided weakness 2/5, awake, alert, and oriented to person, place, and time. Denied swallowing difficulties, speech therapy consult x 2 was negative each time for aspiration. No visual deficits. Denied pain.
Medications: ASA 81mg PO daily; Tylenol 650mg PO q 4 hours prn for pain;

CVP: Placed on a cardiac monitor, findings indicated normal sinus rhythm. Vital signs taken every 4 hours, pulse 62 to 82; blood pressure 103 -162/53-95; respirations 16 to 20. Lung sounds clear to auscultation. Oxygen Saturation on room air = 98%.
Medications: Sinvistatin 40mg PO daily; Lovenox 40mg Subcutaneously daily;

GI: Abdomen soft, non-tender, distended, + bowel sounds. Bowel movement x 1 on 10/17/07. Medications: Colace 100mg PO bid; Senna 2 tablets daily x 3 days; MOM 30ml PO x 1; MOM 15ml PO q 4hours prn;

GU: Voids freely requiring assistance to the commode/bathroom. Output approximately 1000ml/day. Brief episode of dysuria on admission, 10/12 straight catheterization, UA, UA C&S obtained.

Integumentary: Intravenous access in left arm 22 guage capped angiocatheter flushed routinely with normal saline, patent for the entire hospital stay. Braden Score – consistently 15 indicating at risk for skin breakdown due to mobility issues. Skin integrity was monitored and interventions to prevent breakdown instituted daily.

Musculoskeletal: Active ROM right side; PROM left side; Required assistance of 1 to get OOB to chair/wheelchair. History of recent balance problems. Fall risk assessments completed daily; fall prevention measures instituted daily.
Medications: Oscal with Vitamin D one tablet PO bid; Fosamax 70 mg po weekly;

Psychosocial: lives with son/daughter in a two story home; occupation: Reverend; patient was independent with ADLs prior to admission.

Diagnostic studies: Carotid Studies; TEE; MRA of head and neck; MRI had to be stopped due to patient experienced possible reaction to gadolinium.

Medicine History & Physical Assessment

Patient: Walker, Florine

Chief Complaint: Left hemiplegia for 24 hours.

Initial History of Present Illness:
Florine Walker is a 76 year old female who reported symptoms of numbness on the left side and gradual weakness of the left arm and leg that started around 6 days ago. There was no associated right-sided symptoms.

Past Medical and Surgical History:
1. Hypertension
2. Hyperlipidemia
3. Osteoporosis.
4. Bilateral knee degenerative joint disease.
5. Left hip replacement.

Social History:
She has never smoked or drank. She is a reverend.

Family History:
Her son/daughter also had a transient ischemic attack in March. She has four children and apparently they have cardiac problems.

Medications:
Medications at home are Fosamax 70 mg weekly and aspirin 81 milligrams a day.

Review of Systems:
Review of systems is negative for change in vision. Positive for slight headache. Negative for sore throat, drooling or trouble swallowing. Negative for chest pain, shortness of breath or abdominal pain. Positive for dysuria over the last day. Positive for weakness of a neurologic nature on the left side. Negative for any weakness on the right side. Positive for left sided numbness. Negative for any complaints of bleeding, blood in her stools, vomiting, fever, focal rash or weight loss.

Allergies:
Oxycodone

General:
She is pleasant, awake and fluent and in no acute physical distress.

Vital signs:
Temperature is 36.5. Pulse is 71. Blood pressure is 134/42. Saturation is 98%.

HEENT:
Eyes – Extraocular movements are intact. Anicteric. ENT exam reveals moist mucous membranes. No posterior pharyngeal erythema.

NECK:
Negative for goiter or lymphadenopathy. Bilateral carotid bruits are noted

Cardiovascular:
Regular rate and rhythm. S1 and S2. A II/VI systolic ejection murmur is noted at the right upper sternal border. .No heaves, rubs or gallops.

Pulmonary exam:
Clear to auscultation bilaterally without any rales, wheezes or rhonchi.

GI exam:
Positive bowel sounds Soft. Non tender. Non distended. Without any hepatosplenomegaly, guarding or rebound.

Extremities:
No clubbing, cyanosis or edema in any extremity.

Neurologic:
1/5 strength in Left arm flexion and extension. 2/5 in Left hand grip
1/5 strength in Left knee flexion and extension, Left foot dorsiflexion and plantar flexion.
5/5 in strength in the Right arm and leg.
Cranial Nerves II-XII intact.
Unable to go from sit to stand on her own.

Skin:
No rash noted.

STUDIES:

Laboratory:

SMA-6 normal
Cardiac enzymes were negative X 3 sets
LFTs were normal.
Fasting lipid profile showed Total Cholesterol 260, HDL 64, LDL 170, and Triglycerides 132.
Hemoglobin A1c 5.16.
UA was normal.
CBC was normal.
Vitamin B12 442 (normal)
Folate level is greater than 20. (normal)

Radiologic:

- **MRI of the brain** - showed an acute infarct involving the right lentiform nucleus and corona radiata extending to the lateral margin body of the right lateral ventricle. Diffuse small vessel ischemic disease. No intracranial mass.
- **MRI of the neck without contrast** - showed 80% stenosis of right internal carotid artery, minor atherosclerotic involvement of the common carotid bifurcation, probable occlusion of the right vertebral artery.
- **Chest x-ray:** Mild cardiac enlargement with no lung infiltrate or vascular congestion evident.
- **Trans Esophageal Echocardiogram** - showed left ventricular hypertrophy with >55% left ventricular ejection fraction. No intracardiac mass or thrombus noted. No Atrial Septal Defect or Patent Foramen Ovale.
- **Ultrasound of leg** - negative for DVT.
- **EKG -** shows sinus rhythm with rate of 76. No acute ST-T wave changes, some T wave flattening in lead five.

Occupational Therapy Assessment

Mrs. W. is a 76 year old female admitted to the hospital with left sided weakness and intermittent dizziness. Her past medical history is significant for severe arthritis of her knees, osteoporosis and let hip replacement surgery in The MRI indicates she had a right lacunar infarct. Her lungs are clear and her BP is reported at 134/42 and 139/73 since admission. There is some evidence of orthostatic hypotension.

Mrs. W. lives in a two story home with 4 steps to enter. Her bedroom and the only bathroom in the home is on the second floor. She lives with her son/daughter who is working full time during the day. Mrs. W. is a minister and is currently retired.

She reports she has been having trouble with her balance for the last few months.

Mrs. W. is alerted and oriented x3. Gross evaluation indicates her memory, attention and safety awareness is WNL. Her receptive and expressive language is intact. No further cognitive testing has been done at this time.

Mrs. W. does not present with any sensory or perceptual deficits. She wears bifocals and reports she prefers large print.

Her static sitting balance is fair +. She is able to sit unsupported by leans to the left side. When asked to move or when given a slight challenge she looses her balance and is unable to right herself.

She requires moderate assistance to move from supine → sit, max assist to move from sit → supine and min assist x 2 to move from sit ⇔ stand. She requires mod assist for a stand pivot transfer.

PROM of UE and LE is WFL.

She is able to voluntarily flex her L shoulder and elbow through partial range. She has full AROM in wrist and demonstrates decreased grip strength.

Mrs. W. has not been assessed for dressing upper and lower body yet. She was evaluated for self feeding and is able to do this with minimal assist for set up. She had difficulty with activities requiring bilateral coordination (opening containers, cutting). She required maximum assistance with bathing due to her poor sitting balance. She is max assist for toileting for ambulation and transfers. She requires moderate assistance with handling her clothing.

Precautions: Orthostatic hypotension
Fall risk

Physical Therapy Assessment

Patient is a 76 yo female admitted with left sided weakness and intermittent dizziness. She reports that over the last 2 months she has had some balance problems during walking. MRI indicates a lacunar infarct involving right lentiform nucleus and corona radiata (expect pure motor stroke).

Prior to admission she was independent walking without an assistive device and independent with ADL's. She lives in a 2 story home with 4 steps to enter and a flight of stairs to get to her bedroom and bathroom (bilateral handrails on all stairs.) She lives with her son/daughter who work during the day, and she was responsible for cooking and cleaning. She worked as a minister/reverend. Her past medical history includes osteoporosis, degenerative joint disease in both knees, left hip replacement (2001, with revision in 2004), chronic pain in both ankles, and calf claudication pain after walking less than ½ block, with nightly leg cramps.

Cognition/language: Patient is oriented X3, with attention, memory and safety awareness WNL. Receptive and expressive language intact.

Cardiopulmonary status: Her lungs are clear and her resting BP has been reported since admission at 134/42 and 139/73, some evidence of orthostatic hypotension.

Sensory/perceptual status: No sensory or perceptual deficits. Vision and occulomotor function intact.

PROM: WFL

Motor Control:

Voluntary Movement: Normal in R extremities

LUE: Able to voluntarily flex the shoulder and elbow through partial range, full AROM in wrist, decreased grip strength

LLE: 1/5 in hip, 2/5 knee, 0/5 dorsiflexion, 2/5 plantarflexion

Balance:

Sitting: Able to sit unsupported, but leans to left; loses balance with minimal displacement or active movement.

Functional activities:

Supine -> sit: mod assist

Sit -> supine: max assist

Sit ⇔ stand: min assist x2

Stand pivot transfer: mod assist

Standing: Stood with min assist x 2, holding onto rolling walker, weight primarily on RLE, L foot turned out, patient had dizziness which eased as she stood longer.

Ambulation: Patient was unable to take steps with rolling walker. Unable to stabilize left knee for stance, unable to flex left hip for swing.

Pharmacy Assessment

Medication allergies:
Oxycodone

Medications prior to admission:
Fosamax 70 mg weekly
Aspirin 81 mg daily

Medications on hospital discharge:
Colace 100 mg 2 times a day
Aggrenox 1 capsule 2 times a day.
Aspirin 81 mg daily
Fosamax 70 mg every Monday.
Sinvastatin 40mg daily.
Tylenol 650 mg every 4 hours as needed for pain.
Os-Cal and Vitamin D 500 mg with 200 international units 1 pill 2 times a day
Multivitamin one daily

Social Work Assessment

Bio: Ms Walker is in recovery from a recent stroke and has reported a family history of cardiac problems.

Psycho: Ms. Walker presented as alert and attentive. She was able to make good eye contact and her affect was consistent with her mood. Ms. Walker recently had a stroke and it is recommended that she should be screened regularly for other mental health issues commonly associated with a stroke such as post stroke depression. Ms. Walker was oriented X3 (Person, Place and Time). Ms. Walker's speech was clear and coherent and her thought process was lucid.

Axis I: V71.09 No Diagnosis
Axis II: V71.09 No Diagnosis
Axis III: 436.0 Stroke, watch for hypertension
Axis IV: None
Axis V: GAF = 81

Social: Ms Walker reports she has four children. She has regular contact with her son/daugther, with whom she lives, and her sister who lives nearby. Ms. Walker is a Reverend. Relationship with parishioners unknown at this time. Ms. Walker reports having supports at home and in her environment as well as financial stability and means of survival (Social Security and Blue Cross / Blue Shield).

Spiritual: Ms. Walker is a Reverend. Ms. Walker's relationship with her parishioners is unknown at this time.

Wants: Ms. Walker expressed that she wants to go home.

It is recommended that Ms. Walker seek further advanced care such as a skilled nursing facility or sub acute rehab facility at this time to help facilitate a healthy transition back to her home.

Brief Hospital Course:

The patient was admitted into the hospital for acute ischemic stroke. Neurology, PT, OT, Social Work, and Case Management were consulted. Standard laboratory studies were ordered and noted above. The patient was started on appropriate anti-hyperlipidemic therapy. The patient had multiple imaging studies, pertinent for acute stroke and a high grade stenosis of the right internal carotid artery. Vascular Surgery was consulted and he felt that the patient should wait at least 5 to 6 weeks before going through with a carotid endarectomy. Neurology was also consulted for the acute stroke and they recommended starting the patient on Aggrenox 1 pill twice a day as well as a short course of aspirin 81 mg daily initially. The social worker from the hospital called the family to discuss discharge planning. She is recommending an acute rehabilitation unit stay prior to sending Reverend Walker home. The social worker has given the family a list of rehab units in the local area.

2-28-11