**IPE COVID Inpatient Scenario**



**Patient Summary**

|  |  |  |
| --- | --- | --- |
| Name: **Thomas, Ann**Age: 65DOB: 3/5/1955MRN: 5054010DNR: NoInpatient Healthcare Proxy: YesAdmitting weight: 204 lbs. BMI: 35Height: 64 inches**PMH:** Recent Right CVA; Obesity; Type II DM (NIDDM); Hypertension, Osteoarthritis (OA) Bilateral knees.**PSH:** Bilateral total knee replacements (TKR) | **DEMOGRAPHICS**Gender Identity: FemaleReligion: CatholicHousehold Members: Husband, daughter and one grandchildOccupation: Retired secretaryMarital Status: MarriedRace/Ethnicity: HispanicPrimary language: EnglishPostal Code:10455 (Bronx)Other: Husband lost his deli business during COVID pandemic | **ALLERGIES: NONE****Current medications:**Dexamethasone 6mg IV daily (anti-inflammatory)Heparin lock flush daily Enalapril 2.5 mg by mouth daily (hypertension)ASA 81 mg by mouth daily (circulation)Metoprolol 25mg twice a day by mouth (hypertension)Heparin SQ 5,000 Units two times a day (treats and prevents clots)Pantoprazole 40mg daily by mouth (treats and prevents acid reflux)Metformin 500mg daily by mouth (diabetes)Colace 100mg twice a day by mouth as needed for constipation (stool softener)Tylenol 650mg by mouth as needed for pain on pain scale of 4-6Oxygen 4 liters per minute via nasal cannula continuouslyEnsure Plus 1-2 cans daily orally (nutritional supplement) |
|  |
| **Current history of present illness:** 65-year-old person identifying as Hispanic female initially presented to the Emergency Department with severe shortness of breath; loss of smell and test; fasting blood sugar 245, and oral temperature of 102.4. Patient recently discharged from the hospital a week ago to her daughter’s home, post-Right Cerebral Vascular Accident, and was receiving home PT. While there, the patient was exposed to COVID by a family member. During COVID triage, patient assessment revealed an oxygen saturation of 78% on room air and she was placed on a Venturi mask at 15 liters/minute. As a suspected COVID patient requiring a high-flow oxygen device, Ann met the eligibility requirements for immediate treatment with Dexamethasone plus remdesivir. She was transferred to the COVID ICU and admitted to a negative pressure room where airborne precautions were implemented. A chest x-ray revealed multiple bilateral infiltrates. Testing for SARS-CoV-2 came back positive, confirming COVID-19 pneumonia. The patient spent four days in the ICU without further complications which the physicians attribute to her early antiviral treatment. She was slowly weaned down to oxygen @ 4 liters per minute via nasal cannula, however, her right side extremities have become weaker and she has been experiencing frequent episodes of confusion (delirium)and agitation. Her blood sugars have remained stable range 70-90. Remdesivir has been discontinued but she continues with Dexamethasone. Patient’s current diet is pureed and nectar thick liquids pending speech consult. Patient cries easily and frequently refuses to be touched by her healthcare professionals. After four days in ICU, patient is now being transferred to an isolation room on a medicine unit for evaluation by her interprofessional healthcare team (physical therapy, nutrition, social work, nursing and speech therapy, ad others).  |
| **PAST MEDICAL HISTORY:** R CVA, HTN, OA, NIDDM, Obesity |
| **SOCIAL HISTORY:**Patient with new cognitive deficits. Lives with spouse who recently lost deli business. Lives in an elevator building with 3 steps to enter. Recently retired. Has 2 adult children and 3 grandchildren. One daughter and granddaughter live at home with patient. Social drinker with friends – “now & then”.  |
| **PROGRESS NOTES (ASSESSMENT AND EVALUATION FROM EACH DISCIPLINE)** |
|

|  |
| --- |
| **PHYSICAL THERAPY EVALUATION** **Objective:**Mental Status: Pt lethargic, but cooperative. A&O x 4. Integumentary: skin intactCompression stockings in place.+ IV, 2L O2 via NCVital Signs: HR 78 NSR, BP 130/80, RR 14, Sat 95% on 2 L O2Pulmonary: Slightly diminished breath sounds at bilateral bases with mild cracklesReflexes – L LE 3+, Modified Ashworth Tone 0RLE PROM WFL, MMT >/= 3/5 T/ORUE PROM WFL, MMT >/= 3/5 T/O, Grip strength 22KgLLE PROM WFL except L ankle DF = 0 degrees. AROM presents w/ partial active control of hip and knee and no active control of the left ankle.LUE PROM WFL, AROM limited to partial control of shoulder, elbow and wrist and minimal active control of fingers.Supine to Sit with Min/Mod A. Sat at EOB with min A x 5 min with stable hemodynamic response. Sit to Stand with Mod A3 X times sit to stand: 20 secondsAmb 25’ with WBQC with Mod A secondary to decreased motor control for left swing demonstrating left foot drop and decreased ability to weight shift and weight accept on LLE with inadequate L hip and knee extension. Pt has difficulty following commands and demonstrates perceptual deficits and impulsivity increasing her risk of falls. Pt reports SOB upon ambulation. O2 Saturation decreased to 89 with ambulation.IS to 300 x 10. Increased O2 Saturation to 96.Pt. left seated in bedside chair. VS stable.**Assessment:** Pt presents s/p ARDS and R CVA with good rehab potential. Pt has limited motor control on left extremities but has shown significant improvement from the time of the CVA. Activity tolerance is limited but improving. Functional mobility skills for bed mobility, transfers and ambulation are limited due to L sided weakness, balance impairments, and limited pulmonary capacity. Pt has risk of falls due to perceptual deficits, impulsivity, limited balance, LE weakness, and results of 3x sit-to-stand test. Expect pt to make good progress with daily PT to increase safety and mobility skills. Recommend DC to rehab. Recommend OT and P&O evaluation for a L AFO.**Goals**: Pt will require CGA/S for bed mobility in 1 week; Pt will require min A for all transfers in 1 week; pt will be CGA for amb 150’ in 2 weeks; evaluate stair negotiation as appropriate.**Plan:** Daily PT to include deep breathing exercises, functional mobility training, balance training, neuromuscular re-education. |

 |
| **NURSING PROGRESS REPORT****Objective:** Safety; reorientation to unit/RN/staff/routines with use of white boards; Medication discussion**Goal:** Out of bed to chair with one-person assist. Bowel movement. Use of incentive spirometer**Neuro:** A& O x 2 with intermittent periods of confusion. Denies pain at present moment however speech is slow shows some difficulty speaking. Temp 97.9F (36.6C)**Cardiac:** NSR on cardiac monitor; Pulses present and bounding; (+) cap refill; BP 138/66 manual left arm used; apical pulse 83; positive pedal pulses present and bounding. Fasting blood sugar 82.* BP: Lying: 138/76
* Sitting: 133/73
* Standing: 136/80

**Respiratory:** Breath sounds clear but diminished to bases with crackles; 02 sat 95% on 2L O2; non-productive cough noted. **Gastrointestinal:** Abdomen soft non-distended positive bowel sounds noted x4 quadrants; last BM was 3 days ago -will assess if she is on stool softeners and her diet. **Genitourinary:** Primafit® in place collecting amber colored urine 300 mL; denies burning or pain upon urination. Saline lock #22 to left antecubital placed 2 days ago, site clean dry and intact. #22 right antecubital placed 3 days ago site noted with minimal blood but they both have good blood return and flushed with 10mL of Normal Saline**Integumentary:** Skin intact, free from ulcers. Skin is warm and dry with good skin turgor.**Assessment Summary:** Pt appears pleasant but confused with slow speech; able to express needs with some assistance. Ms. Thomas was asked how she would prefer to be addressed and stated that “Ann” would be appropriate. Ann’s goal for today is to meet with Physical Therapy to assist with getting out of bed (OOB) without experiencing shortness of breath. Ann stated that her husband will be calling her today and would like assistance with video chat. Ann is tolerating her diet but prefers to have something more palatable. Awaiting to review her bloodwork as the results are pending. Ann did complain of a sore throat from being intubated, I gave her some saltwater to gargle. Will return to discuss Ann’s medications and today’s goals placed on her white board.Education needed: Medications, insulin administration when returns home; COVID education on safety precautions, s/s; hand and respiratory hygiene; vaccination information & consent |
| **SOCIAL WORK PROGRESS REPORT** Social work met with patient (Ann) and spouse (Paul) together (virtually) for an initial assessment and subsequently met with each of them separately to provide individualized psychosocial support. Ann is a 65 yo female who lives with her 67 yo spouse in an elevator-accessible building with three steps to enter. Ann and her husband have been married for 30+ years. Both shared that it has been extremely difficult to be separated from one another. In addition to concerns about Ann’s recovery, they are each deeply worried about one another. Paul was working full-time outside the home, but recently lost the family’s deli business. This loss, along with not being able to be with his wife in person, and significant changes to roles and responsibilities has contributed to both of their reported distress. Prior to admission, the patient was independent and worked as an administrative assistant. Patient was self-quarantined for five days prior to her ED admission due to secondary to exposure to her COVID-positive granddaughter visiting from college. Paul states that he will be home as he figures out what his plan is for income. Ann and Paul did express anxiety about their finances, but they reported that they have some savings. Ann is eligible to receive short-term disability from her job. She expressed that she would like to return to work, but is open to retiring as well. Upon retirement, she stated she will receive some benefits from her job. If Ann were to retire at the end of short-term disability, she should be eligible for both Medicare and Social Security. Since Ann and her husband currently have health insurance through her employer, neither she nor her spouse have applied for Medicare. The short-term disability will cover up to 6 months, which she has been paying into from her income. This might allow her to continue to receive non-COBRA health care insurance for this period of time. Patient and/or family to call HR at patient’s job to confirm and discuss short-term and long-term options. Ann’s husband is 67 years old and is eligible for social security and Medicare. Social work discussed options at length with patient and husband and provided phone numbers and websites to consult. Social work outlined Medicare coverage and options to ensure full coverage. Social work helped patient and husband with some questions to ask HR and offered to assist with this or any other part of the process as needed. Patient’s spouse reports that he is in good health and has not tested positive for COVID-19. Ann has 2 adult children and 3 grandchildren. One of the patient’s adult children and patient’s granddaughter live with the patient and her spouse. Ann’s daughter works full-time; however, during COVID, the daughter has been working from home. The patient’s other daughter and her two grandchildren also live near the patient. The patient has reported that she is a social drinker and does not take any drugs other than prescribed medications. She reports that she has been in therapy in the past for depression and anxiety, but was not seeing a therapist at the time of admission. She stated that she would be open to speaking to a therapist remotely upon discharge and has internet access and video capabilities at home. Patient reported difficulty coping with her loss of independence. The social worker administered the 7-item Generalized Anxiety Disorder (GAD-7) and the 9-item Patient Health Questionnaire (PHQ-9). The patient fell within the severe range on both the GAD-7 (anxiety) and the PHQ-9 (depression). Due to Ann’s stroke and the ongoing cognitive assessment, these measures should be readministered upon discharge. Some of the responses could be related to the significant loss of independence. However, the patient reported some pre-existing depression and anxiety that has been exacerbated by her current situation. Social work discussed short-term goals with the patient which includes returning home and regaining her independence. Her longer-term goals are to return to work and to maintain her health. The patient’s spouse reports increased anxiety and would benefit from emotional support as well. Social work recommends ongoing therapy to address, loss, depression, traumatic stress and anxiety. Patient did not express any suicidal ideations, intentions, or plans. Social work will continue to provide emotional support throughout admission and speak with patient and spouse about ongoing support upon discharge. Social work, in consultation with the entire medical team, will continue to work with the patient and family to ensure referral to appropriate resources and provide ongoing support. |
| **MEDICAL ASSESSMENT: SOAP NOTE****Subjective:** 65 yo female with COVID-19, requiring mechanical ventilation s/p successful intubation, hospital course complicated by CVA with left hemiparesis, s/p tPA. Patient successfully extubated, now being transferred from ICU to med-surg floor. She is looking forward to going home.**Medications**: Enalapril 2.5 mg by mouth dailyASA 81 mg by mouth dailyMetoprolol 25mg twice a day by mouthHeparin SQ 5,000 Units three times a dayPantoprazole 40mg daily by mouthColace 100mg twice a day by mouthFerrous Sulfate 325mg daily by mouthTylenol 650mg by mouth as needed for pain on pain scale of 4-6Complete dexamethasone 6 mg IV daily x 10 days**Objective:** Patient is sitting comfortably, Alert and oriented x3 HR 79 BP 130/80 O2 sat 95% 2L NC Tmax: 98.9; Tcurrent: 98.7**Cardiovascular**: Normal S1, S2, no murmurs/rubs/gallops**Pulmonary:** Slightly diminished breath sounds at bases bilaterally with mild crackles.**Gastrointestinal:** Normoactive bowel sounds; soft, non-tender, non-distended**Neuro**: Alert and oriented x 3: slurred speech. LUE/LLE motor strength 3/5.RUE/RLE strength 5/5. No change in exam overnight. **Lab results**: SARS-Co-V-2: positive**Assessment**: Patient with acute ischemic CVA, s/p tPA treatment. Patient had respiratory failure requiring mechanical ventilation. Patient successfully extubated and currently on 2-4 L supplemental O2 per nasal cannula**PLAN:****CVA:** Patient may have underlying hypercoagulability in the setting of acute COVID-19 infection, but there is no evidence of embolic stroke. Plan to continue anti-platelet therapy, BP management. Will require PT/ speech therapy evaluation and treatment. Advance diet as tolerated.**CV**: Hypertension controlled. Continue with Vasotec.**Pulmonary**: Patient with history of COVID-19 infection. Completed course of corticosteroids. Will titrate oxygen as tolerated. Repeat chest X-ray to follow up on abnormal lung exam, though this may just be persistent abnormalities related to COVID-19 pneumonia. Continue with incentive spirometry to prevent atelectasis. **F/E/N**: Check chem 7 today to monitor renal function. Continue with I/O monitoring**Heme/ID**: Check CBC, PT/PTT today.**GI**: Exam is stable. Follow up with recommendations regarding diet.**Prophylaxis**: Continue with DVT prophylaxis |
| **Speech Therapy Evaluation****Objective:**Pt. demonstrated good comprehension skills, completed task of pointing to pictures at 70% and improves to 85% with personally relevant materials with perceptual preferences noted. Difficulty attending to stimuli, uses head nod/shake, significant word-finding deficits in all contexts. Decreased awareness and poor insight into functional safety parameters, e.g., unable to use call bell for assistance. Some dysphonia noted. Last night Pt reported intermittent facial paralysis and increased awareness of loss of sensation on L side with increased frustration noted.Pt. demonstrated moderate oropharyngeal dysphagia bedside characterized by reduced mastication, moderate oral residue post swallows, delayed swallows, reduced pharyngeal elevation, and some protective coughing post swallow given mechanical soft textures and thin liquids. Pt. independently cleared oral residue using lingual sweep technique. **Assessment:** Mental Status: Pt lethargic but cooperative. A & O x 4. VS: BP: 130/90 HR: 78 Resp: 24 Temp: 98CC**:** Pt presents s/p ARDS, R CVA with L sided UE weakness, left-side deficits of perception and function, limited pulmonary capacity, harsh voice quality post intubation expected to resolve, dysarthria and word finding deficits. Pt. is currently on a mechanical soft and nectar thick liquid diet. Recommend diet downgrade to puree texture pending MBS swallow study and nutrition consult. Crush large medications and administer with puree texture. Additional cognitive deficits include reduced sustained attention, easily distracted, poor insight and judgement which may impact safe completion of functional tasks and ADLs. Pt reports frustration, significant distress with dysarthria, dysphagia, and additional symptoms but strong drive to rehab. Recommend MBS swallow study, nutrition consult, social work consult, and OT evaluation.**Goals:** Pt will communicate wants and needs using visual instruction mindful of presentation for support when needed. Pt will engage in personally relevant attention and memory tasks.Pt will use strategies to increase speech intelligibility during structured conversations.Pt will maintain puree (IDDSI 4) and nectar thick liquids (IDDSI 2) pending MBS Study and Nutrition consult.**Plan:**Daily ST to include integration of visual instruction as needed to facilitate speech and language production, attention and memory tasks and maintenance of dysphagia diet. |
| **NUTRITION ASSESSMENT** Pt visited for nutrition consult. Pt currently receives mechanical soft diet (IDDSI 6) with nectar thick liquids (IDDSI 2). Pt had received enteral feedings while intubated. Pt reports NKFA and no weight changes PTA, consuming a regular diet with no restrictions. She prepared food herself and finds the food currently provided to her unpalatable. Reports some swallowing difficulties but insists she “can handle” the food as provided.Dx: Pt is s/p ARDS with mechanical ventilation, and s/p CVA with left hemiparesis.PMH: HTNNFPA: Abdomen soft, non-distended, + bowel sounds per Nsg, skin intact per Nsg, no muscle or subcutaneous fat wasting noted upon visual examination and palpation of face, shoulders and arms.Current labs: not availableCurrent nutrition-related drugs: Ferrous sulfate, pantoprazole, ColaceCurrent weight: 204 lbs at admission, height 64 inches, BMI: 35 – overweight.EER: 1705 – 2045kcal/d based on 25-30kcal/kgProtein requirement: 102-136g/d based on 1.5-2.0g/kg,Fluid requirement: 1705-2045cc/d based on 30cc/kg**Nutrition Diagnoses**:Swallowing difficulty RT decreased function 2’ R CVA AEB SLP assessment and pt report of tolerating mechanical soft diet (IDDSI level 6)Inadequate oral intake RT food preferences and sore throat from intubation AEB pt report and Nsg record of intake at 50-75% of food served.Inability to self-care RT limited functional skill 2’ R CVA AEB assessment by PT**Nutrition Interventions**:Continue Mechanical soft diet (IDDSI 6) and nectar thick liquids (IDDSI 2) consistencies, Recommend high protein, high energy, low salt (provides 4g NaCl/d, 4g potassium per day)Add Ensure Plus dailyProvide feeding assistanceHonor patient’s food preferencesRecommend consult with OT for adaptive feeding toolsContinue collaboration with SLP for possibility of diet advancement, monitor result of MBS**Goals:**Maintain/increase body weight.Increase intake to 75-100% of foods served.Tolerate diet consistency.**Monitoring/Evaluation**:Monitor oral intake,Monitor body weightMonitor for S&S of aspiration during eatingMonitor labs as available |
| **DENTAL HYGIENE/ORAL HEALTH ASSESSMENT** Chief Complaint: patient reports discomfort in the mouth, difficulty swallowing, frequent coughing. Upon admission, patient noted loss of taste and smell which is still persistent. Extraoral Examination: No facial swelling. Facial asymmetry related to right CVA stroke Intraoral Examination: No hard tissue or soft tissue trauma noted from intubation. Periodontal disease (Stage II, Grade B) complicated by Type II Diabetes Mellitus. Mild residues noted in oral cavity (food rumination), patient is able to clear the food with intake of water. Palatal lesion noted as a red flat lesion starting in the soft palate extending anteriorly to the hard palate. Patient chief complaint is “mouth is sore and has a sour taste.” Assessed that patient has difficulty swallowing, recommend consult with OT/SP* Xerostomia noted

 |
| **OCCUPATIONAL THERAPY ASSESSMENT****Occupational Profile:** Ann is a 65yo Hispanic female s/p COVID-19, ARDs, s/p RCVA w/ L hemiparesis. PMH: HTN. * Occupational History: Prior to admission, Ann was working as a secretary. She enjoys spending time with her grandchildren and occasionally helped with childcare as needed. She also has previously enjoyed attending baseball games, making jewelry, and dancing.
* Social Hx: lives in elevator building with husband, one adult daughter and granddaughter. Additional adult daughter and grandchildren live nearby.
* Contexts that present as potential facilitators: supportive family, supportive church community
* Contexts that present as potential barriers:environmental factors of the home, work demands, needs for DME and adaptive equipment.

**Subjective:** Ann reports feeling tired and missing her family. **Objective:** Ann participated in OT session at bedside. She was AAOx4. Vitals prior to start of session: HR 78 NSR, BP 130/80, RR 14, Sat 95% on 2 L O2. RUE AROM WFLs, MMT = 3/5 throughout, grip strength 22kg; LUE PROM WFLs, limited AROM of shoulder, elbow and wrist and minimal active control of fingers. Ann exhibited decreased attention to task and mild impulsivity during ADL tasks. She required verbal prompts to visually locate items to the left of midline during grooming activity. Ann required moderate assistance to complete grooming activity to wash her face while in supine in bed. She required set up and verbal prompts for thoroughness, especially for left of midline. Ann required moderate assistance for bed mobility from supine to sit. She required maximal assistance to don a hospital gown sitting EOB. She required assistance to place her left UE into the sleeve of the gown. She was not able to tie a bow to fasten the gown. She required maximal assistance to don pajama pants while seated at the edge of the bed. She required frequent rest breaks while performing ADLs, and required verbal prompts for safety and to attend to left of midline during dressing and grooming activities. She required moderate assistance for stand-pivot transfer to/from bedside commode. She required verbal prompts for safety and positioning of her LUE during bed mobility and transfers. She required moderate assistance for bed mobility to return to supine at the conclusion of the session. The nursing call button and bedside tray were placed on the right side of bed and safety precautions were reviewed with Ann for fall prevention. **Assessment:** Ann requires mod-max assistance for ADLs, functional transfers, and safety awareness. She fatigues easily which impacts her ability to complete ADLs at this time. She demonstrates potential to improve in the areas of ADLs with daily occupational therapy. Recommend inpatient rehabilitation prior to discharge home. Further assessment of IADLs and home safety check are recommended prior to discharge home. **Plan:** Ann will participate in daily occupational therapy session to facilitate independence with ADLs, promote safety awareness, and provide patient/family training in compensatory strategies for ADLs. Ann will require home safety check and further assessment of IADLs prior to return home. **Goals:**1. Ann will complete grooming activities to wash her face with minimal assistance after set up within 1 week.
2. Ann will don a button-down shirt with moderate assistance and set up within 1 week.
3. Ann will incorporate 2/2 compensatory strategies with moderate verbal prompts to improve ability with perceptual deficits during ADLs with within 1 week.
 |
| **PHYSICIAN ASSISTANT ASSESSMENT** |

**https://www.covid19treatmentguidelines.nih.gov/management/clinical-management/hospitalized-adults--therapeutic-management/**