<u>Identifying Data</u>
Full Name: MK
MRN: omitted
Room: omitted
Address: omitted
Date of Birth: 3/22/1943
Date & Time: 7/18/22
Location omitted
Religion: omitted
Source of Information: staff and son
Reliability: reliable
Mode of Transport:

HPI: 78yo F admitted to long-term care floor in 2020, requires assistance with functional mobility and all ADLs. Pt has grade 1 meningioma, dementia, seizure disorder, dysphagia, constipation, HTN, HDL osteoporosis, h/o fall, dysphagia seen today for monthly assessment. Pt is non-verbal, unable to assess cognitive status. Pt was reported to eat 50% or less for 2 or more meals in the day by RN Kleiner. Extra fluids intake by mouth provided. Pt with hx of fair-poor appetite. Multidisciplinary care conference held on 6/28/22 about fair-poor appetite. Pt on Chinese/pureed diet (level 4 texture), thick level 2 consistency with ensure enlive daily. She requires full assistance in feeding and is on careful handfeeding as tolerated by staff and family. One moisture associated skin damage on sacrum with light serosanguinous exudate; normal surrounded tissue no s/s of discomfort. Treatment cleansing with normal saline in between dressing changes; Primary dressing with antimicrobial foam. Preventative measures of heel suspension/protection device, moisture control/incontinence management, moisture barrier application, turning/repositioning and nutrition/dietary supplementation are all in place. Pt noted to not have bowel movement x 3 days on 7/18/22. Pt on Lactulose 30ml (10 gm/15 ml) by mouth BID for constipation. Milk of Magnesia suspension 400 mg/5 ml give 30 ml by mouth ordered on 7/18/22. If no bowel movement by PM on 7/18/22 two units of fleet enema is ordered. Last blood work was done on 6/16/2022 slightly elevated sodium and BUN.

Advanced directives in place: MOLS: DNR/DNI/DNH/No tube feeding, No weights, trial of IVF, ABX as indicated for palliative care.

Allergies: No known allergies
Medications:
- Lactulose 30ml (10 gm/15 ml) by mouth BID for constipation
- Hydrochlorothiazide Capsule 12.5 MG for Hypertension
- Levetiracetam 100mg (100mg/ml) BID daily seizure prophylaxis
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Pmhx:
- Recurrent meningioma, 2013, 2021

- Cerebrovascular accident, 2017
- Displaced apophyseal fracture of Right Femur, 2015
- Dementia, 2019
- Seizure disorder, 2020
- Dysphagia, 2021
- Constipation, 2021
- HTN, 2000
- HLD, 2000
- Osteoporosis, 2012

Surgical hx:
- Left frontal Craniotomy, 2019
- R artificial hip joint, 2015

Family Hx:
- Unable to obtain pt nonverbal; son unable to answer

Social History:
Occupation: worked in China in the industrial plant when she was younger, per son, but has helped family business in Chinatown for most of his life.
Education: Unable to determine
Travel: Grew up in China, came to the United States
Smoking: Pt did smoke most of her life, per son
Alcohol: Pt did drink alcohol, but not too much per son
Drugs: Son denies any drug use
Sex: unknown
Exercise: pt is unable to exercise due to condition
Diet: Chinese/pureed diet (level 4 texture), thick level 2 consistency with ensure enlive daily

<u>Review of systems:</u>

General: Pt with reported low appetite, son seen trying to feed patient with 50% of the food on her shirt, pt unable to swallow on command. CRNA and son deny any recent occurrences of fever, chills, sweats.
Skin, hair, nails: CRNA denies any changes in texture of skin/hair, excessive dryness or sweating, changes in moles, any rash. Pt does have a moisture associated damage on sacrum
Head: CRNA denies any seizures or signs of distress.
Eyes: Pt does not use of contacts/glasses, proptosis and anisocoria are present.
Ear: No use of hearing aids.
Nose: No epitaxis, obstruction and discharge

Mouth/throat: No bleeding gums, no teeth present, dentures are not used due to fitting and risk of choking for patient.
Neck: CRNA denies pt having any localized swelling/lumps, stiffness/decreased range of motion
Breast: CRNA denies pt having any change breast pigmentation, size or nipple discharge
Pulmonary system: CRNA denies pt having any cough, wheezing, hemoptysis or tachypnea.
Cardiovascular system: CRNA denies pt having any episodes of HTN, tachycardia, irregular rhythms.
Gastrointestinal: CRNA states that her appetite is poor and so is her fluid and medication compliance because you can't tell if she's swallowing and you often see the food dribble out of her mouth, , No reports of vomiting, diarrhea, jaundice, change in bowels, hemorrhoids, rectal bleeding, blood in stool. Pt has not had a BM in 3 days.
Genitourinary system: Pt noted to have less urine in past couple days; has never been high urine output but diaper is almost dry in past two days.
Nervous: CRNA deines pt having any seizures or loss consciousness
Musculoskeletal system: CRNA denies any changes in pt strength (1/5), degree for PROM or deformities.
Peripheral vascular system: CRNA denies pt any or any color change in pt skin
Hematological system : CRNA denies any bruising or bleeding , lymph node enlargement, history of DVT/PE
Endocrine system: CRNA denies any polyuria.
Psychiatric: unable to assess

Physical

General: Obese female sitting, slightly slumped over in wheelchair. The left side of her forehead is protruding and her eyes make slight movements when speaking to her. Pt does not appear in acute distress but non-verbal and unable to make needs known

Vital signs:

BP: 118/76

R: 14 P: 82bpm, reuglar O2:98 on room air

T: 97.6 F
Height: 5'3" weight: 163

Skin: warm & dry texture, appropriate color for ethnicity, adequate skin turgor. 1 moisture associated skin damage on sacrum with light serosanguinous exudate; normal surrounded tissue no s/s of discomfort

Hair: Hair is thin with some areas with less hair and past cranial surgery scars seen with different hair growth patterns over this protion
Nails: No abnormal coloring or markings; clubbing, capillary refill <2 seconds in upper and lower extremities
Head: Head is not normocephalic; left side of head/forehead are protruding due to brain tumor; nontender to palpation throughout head
Eyes: Unable to assess visual acuity. No corrective lenses. Conjunctiva is pink and moist, No hemorrhage, or abnormal sclera color seen. Unable to assess all extraocular movement however eyes moves directions; proptosis noted; Pupils are round but not symmetrical; anisocoria noted with R pupil measuring <2 and L pupil ~2; B/L pupils reactive to light.
Nose: Nasal mucosa is pink and moist. The nasal septum is midline. Nares are patent bilaterally.
Ears: Ears are symmetrical in size/placement. No lesions/masses / trauma on external ears noted. No tenderness to palpation of pinna or tragus, mastoid process. Able to visualize TM with noted sclerosis on TM but no signs of infection.
Sinuses – No signs of tenderness over bilateral frontal, ethmoid and maxillary sinuses.
Throat: Oral mucosa pink and moist; Pt with no teeth and no dentures during time of evaluation. Unable to evaluate tongue symmetry or tonsils.
Neck: No lymph node swelling noted; Trachea id midline, thyroid gland normal size; Carotid pulse strength; any bruit. JDV presence
Cardiovascular: No lifts, heaves, or thrills. Heart rate and rhythm are normal. No murmurs, gallops, rubs or abnormal sound auscultated. S1 and S2 are heard slightly distantly could be due to patient mass.
Chest/Lungs: Chest wall with symmetrical rise, signs of trauma/tenderness. No signs of respiratory distress. Anterior lung sounds are harder to hear due to mas but clear in all lobes bilaterally, No rales, Rhonchi, or wheezes heard.
Abdominal: Abdomen is hard and slightly distended. No tenderness noted however pt is not able to make needs known.
Musculoskeletal: Upper and lower extremities appear flacid, able to do PROM of 45 degrees with B/L arms and PROM 90 degrees with legs. No tenderness or deformity noted. Muscle strength 1/5 in all extremities bilaterally. Capillary refill is less than 3 seconds in all extremities. Pulses palpability in all extremities.
Neurological: Pt is awake with some eye movement when spoken to but unable to assess level of alertness or oriented to person, place, and time. No motor function examined during my evaluation. Sensation unable to be examined due to pt non-verbal status.

Assessment:

1. Dementia associated decreased PO intake
    a. RN alert for when pt eats 50% or less for 2 or more meals in the day
    b. Extra fluids intake by mouth provided
    c. Careful hand feeding in place
    d. Supplement added to each meal

2. Constipation
    a. 3 days with no bowel movement
    b. Pt abdomen non-tender
    c. Lactulose 30ml (10mg/15ml) given daily for constipation
    d. Milk of magnesia 400 mg/5 ml give 30 ml by mouth ordered on morning of 3rd day with no BM
3. Hypertension
    a. MRI shows extension of tumor - S/p Focus meeting w/ family - son elected to defer surgery. MOLST updated
    b. Pt on Hydrochlorothiazide Capsule 12.5 MG daily
    c. Blood pressure measured weekly, lowest in past two months 97/63 and highest 160/86
4. Seizure
    a. No reported seizure activity
    b. Levetiracetam 100mg (100mg/ml) BID daily seizure
5. Dysphagia
    a. On Pureed diet, Puree Level 4 texture, Mildly Thick (formerly Nectar) Level 2 consistency with extra encourage PO intake/fluids as tolerated
    b. Pt is carefully handfed with aspiration precautions

Plan

1. Dementia associated decreased PO intake
    a. Multidisciplinary meeting held on 6/28/22 with dietary, social work, nurse and recreation
    b. Continue careful hand feeding, extra fluid by mouth and supplements
    c. Pt on palliative care with no weekly weights
    d. Monitor for signs of dehydration
    e. Continue treatment of moisture associated skin breakdown and preventative measures for potential skin breakdown
    f. Continue to discuss pt condition and potential complications with family
2. Constipation
    a. Continue encouragement of extra fluid
    b. Continue lactulose
    c. If milk of magnesia does not produce BM by PM on 7/18/22, two fleet enemas to be given
3. HTN
    a. Continue to BP/HR Monitoring Weekly. Call MD if SBP < 90 or > 160, or if HR < 50 or > 110
    c. Continue Hydrochlorothiazide Capsule 12.5 MG daily for HTN and r/o increased ICP
6. Seizure

a. Continue monitoring for seizure activity and Levetiracetam 100mg (100mg/ml) BID daily seizure

7. Dysphia
    a. -c/w current diet - Pureed diet, Puree Level 4 texture, Mildly Thick (formerly Nectar) Level 2 consistency
    b. c/w encourage PO intake/fluids as tolerated
    c. careful handfeeding as indicated
    d. aspiration precautions
    e. oropharyngeal suctioning q 2-3 hrs PRN