Full Name: SP

Address: Taken but omitted for PHI
Date of Birth: 5/21/1984
Date & Time: 7/8/22
Location: Gouverneur skilled nursing facility
Religion: N/A
Source of Information: Self
Reliability: Reliable

Chief complaint: R hip pain x 1 day

HPI: 38 year old male admitted to long-term care floor in 2019, requires assistance with functional mobility and all ADLs. Pt with C1-C4 complete quadriplegia, chronic neurogenic bladder, autonomic dysfunction, tracheostomy, chronic candida auric colonization and chronic severe protein-calorie malnutrition and healing stage 4 sacrum ulcer. Pt seen today due to reported R pain starting 7/7/22 at 8pm. Pt was given acetaminophen 650mg q 6 for pain. Patient is seen with two nurses at bedside during dressing change. Pt states that he does not feel R hip "pain" but more discomfort x 1 day. He describes the discomfort as "tightness". Pt states he has felt this tightness before but he is considered this time because he also woke up yesterday with his legs more "splayed" or stretched out than normal. Pt asked nurse to stretch his leg out during dressing change and stated that this ability for his legs to be stretched this far was new. Pt has healing stage 4 pressure on R buttocks but pt states it is not from this. Pt was able to communicate where the pain was precisely while I was palpating. Discomfort was isolated to top of femur and not at acetabulofemoral joint. However pt states he would still like the x-ray to make sure his hip is not dislocated. Noted in chart are orders for nursing staff to provide PROM to all joints in available range x 10 reps per OT and B/L LE's ROM Ex's for 2 x 10 reps per PT.

Past Medical History:

- Candida Auris in urine, MDRO
- C3-C4 injury via MVA in October 2018
- Quadriplegia
- Multiple pressure ulcers
- h/o vertebral osteomyelitis
- history of pseudomonas pna

Past Surgical History

- Status post tracheostomy, 2009

Allergies: No known Allergies

Medications:

- Acetaminophen 650 PRN for pain as needed
- Midodrine 10mg PRN for hypotension <100/<80
- Senna 7.5mg, two tablets before bed daily for constipation

Status: Full Code

Decision Capacity: Full

Social history:

- Lived with his mother and worked in lower east side as a chef before his motorcycle accident
- Marital status: never married
- Admits to using a marijuana smoker and alcohol prior to accident
- Denies history mental illness
- Depression screening: scored 12 points; moderate depression on PH-9

Family Hx:

Father: unknown

Mother: alive, HTN, DM

Siblings: 2 brother(s) , 2 sister(s) – healthy

Physical exam:

General Appearance: Alert and oriented x 3, thin male in no acute distress with contracted limbs in bed

HEENT: normocephalic; non-tender to palpation; PERRLA, non-icteric sclera, no nystagmus, conjunctiva clear, Fundi: no gross abnormality noted

Pharynx: oral mucosa moist, no exudate, lesions or erythema

Nasal septum: midline

Mouth: teeth intact, cavity filling on front tooth

Ear canals: no lesions, TM intact, minimal cerumen

Neck: supple, no thyroid enlargement, no lymphadenopathy, no carotid bruit, no JVD, (+) limited ROM, (+) covered up trach stoma

HEART: non-displaced PMI; normal RRR; normal S1S2 no murmurs or clicks

Skin: warm, moist, no rash; 3cm x 4xm healing stage 4 sacral ulcer present; granulous tissue noted, not exudate

LUNGS: Clear to auscultation bilaterally; no rales, rhonchi

Abdomen: soft, tender, non-distended

Genitourinary: Suprapubic catheter in place; diaper removed for examination; circumcised

Extremities: contracted; no edema; +2 radial bilaterally; no clubbing, cyanosis or tremors

Foot exam: Toe nails trimmed; slight yellow discoloration, no signs of fungal infection ; no abrasions, open wound or fissues noted; dry skin noted on R foot. Absent ROM; sensation intact to light and sharp on B/D dorsal aspects however diminished light sensation to L Planta pedis ; +2 dorsalis pedis and posterior tibial pulses bilaterally; warm and moist skin bilaterally.

Neuro: alert and oriented x 3

Mental Status Exam: alert and oriented to person, place and time; Irritated Mood/Affect

Musculoskeletal: Paralyzed upper and lower extremities; 0/5 muscle strength in R shoulder/arm, bilateral legs and torso. L lower arm and hand with 2/5 strength and some limited motion. Pt expresses pain when limbs are moved by anyone aside from his CAN ; (+) discomfort/tightness R upper anterior thigh muscle; soft and hard sensation intact on bilateral upper arms, legs and L foot. R foot with decreased sensation to light touch on dorsal aspect.

Review of Systems

General/Constitutional: no fatigue, weakness, fever/chills or unintentional wt loss in past 6 months

Head and Neck: no headache, no dizziness, no lightheadedness.

Eyes: Eyes normal vision, no redness, no blind spots, no floaters.

Ears: no earaches, no fullness, no tinnitus.

Nose and Sinuses: no stuffiness, no discharge, no itching, no nosebleeds.

Mouth and Pharynx: no bleeding gums, no sore throats, dry throat, hoarseness

Neck: no goiter, no neck stiffness or pain**;** or swelling of lymph nodes

Heart: no chest pain or discomfort, no syncope, no dyspnea on exertion, no orthopnea, no PND, no edema, no cyanosis, no heart murmurs, no palpitations.

Lungs: no pleuritic pain, no SOB, no wheezing, no stridor, no cough, no hemoptysis.

Gastrointestinal:, no indigestion, no abdominal pain, no heartburn/reflux, no excessive belching or flatulence, no nausea/vomiting, no hemetemesis, normal bowel movement frequency, no rectal bleeding, no hemorrhoids; **(+) constipation, (+) soft stool**

Genitourinary: **(+) suprapubic catheter** due to neurogenic bladder; denies any pain at site or hematuria

Musculoskeletal: **(+) R hip pain, (+) R shoulder pain, Absent ROM in R and B/L extremities, limited ROM in L arm/hand**, , no swelling or redness in joints,

Skin: no rashes, no lumps, no itching, no pigmentation, no changes in hair and nails; (+) ulcer on sacrum; (+) dryness on feet

Neurologic/Psychiatric: no fainting, no seizures, no tremor,, good memory and speech, no headache; no nervousness, no tension, no unusual perceptions, no current suicidal ideations **(+) numbness/tingling felt in R foot; (+) irritated mood (+) depression via survey**

Hematology: General no anemia, no easy bruising or bleeding.

Allergy/Immunology: General no skin rashes, no trouble breathing.

Men Only: no hernias, no discharge or sores on penis.

Vitals: Temperature: 97.8 F (forehead) HR: 67bpm BP: 98/68 sitting (L arm)
RR: 21 Osat: 98% room air Height: 70 inching (lying down)
Weight: 91.4lb BMI: 13.1

Assessment:

1. Right anterior pain discomfort
    a. Isolated area of discomfort top of femur and not at acetabulofemoral joint no skin breakdown seen
    b. No discomfort upon PROM of R hip
    c. No discomfort upon palpation of R acetabulofemoral joint
    d. Pain not felt at buttocks where pressure is
    e. OT and PT have standing order for nursing staff to provide PROM to all joints in available range x 10 reps and B/L LE's ROM Ex's for 2 x 10 reps

Plan

1. Right anterior thigh discomfort

    a. R hip xray ordered, will FU
2. OT and PT have standing order for nursing staff to provide PROM to all joints in available range x 10 reps and B/L LE's ROM Ex's for 2 x 10 reps
    a. Follow-up with charge nurse and CNAs to see if this order is being carried out
3. Physiatry consult for possible Baclofen/tizanidine Rx

Follow-up on 7/11/22:

1. Results of X-ray: 7/9/22

Examination:Hip - Right (2 Views)
Diagnosis :Pain in right hip
Hip - Right {2 Views} [HIR]:
There is severe deformity of right hip joint with narrowed joint space. There is deformed and small right femoral head and neck. There is marked abduction deformity of hip joint alignment. There is no gross fracture.
IMPRESSION:
Advanced right hip joint alignment deformity.

2. Physiatry consult

Pt seen seen for contractures. He reports his wounds are all closed. He states he is planning to see a surgeon for possible surgical correction of his lower extremity contractures. He reports he does not want to try any new medications and would like to be evaluated by a surgeon. Per physical exam pt has some movement in proximal upper extremities L>R. Does not want me to try and straighten his lower extremities due to positioning.

Assessment/Plan: 7/11/22

- Encourage bedside exercises and OOB activity with appropriate assistance. Range of motion at bedside of all limbs.
- At this time, patient is not interested in any medications to assist with spasticity / contracture. He is interested in a surgical consultation. Reports he is planning to be evaluated at HSS.
- Precautions: falls/safety
- Pain control if needed. Goal to have pain level <4/10. Ibuprofen 400 mg po q6h prn.
  Monitor skin and continue with position changes. Prevention of skin breakdown.

- Nutrition needs, supplements and follow up

My follow-up note:

Pt seen today for F/U regarding his R hip pain. Pt was evaluated for R hip pain on 7/8/22 which was found to be more of R anterior thigh tightness. Pt refuses muscle relaxers which are recommended to help with contractures however pt states he does not “trust medication” and states he “sees people like zombies in this nursing home from medication”. Discussed xr-ay findings that showed a R hip deformity related to his contracted state but no hip fracture or dislocation. Pt states that his CAN does his range of motion exercises every day during his dressing change. Pt mother was called this morning due to her requesting surgery consult for release of contractures. Physiatry was spoken in regard to this and stated that he may not be a candidate for this surgery as it usually done for an isolated contractures. However pt mother would like him to have another work up at Mount Sinai and for them to find a surgeon at Hospital for Special Surgery. Pt has no other complaints at this time.

Follow-up note today 7/14/22:

38yo M with C1-C4 complete quadriplegia, chronic neurogenic bladder, autonomic dysfunction, tracheostomy, chronic candida auric colonization and chronic severe protein-calorie malnutrition seen today for follow-up. Pt had his suprapublic catheter changed today by NP Lising. Pt is upset today about pain that was felt on Monday at 8pm. Pt states that he had severe pain 8/10 in his R shoulder and requested the hydromorphone 4mg he has prescribed for breakthrough pain PRN however it had been discontinued as it was PRN x 2weeks with no dose given. Pt was very upset as the nurse did not report this to the on-call doctor and he never received any pain medication beyond Tylenol. Pt states that the nurse name was Jamel and she stated that he didn’t have that medication anymore for pain. Pt states that he had to call his mother who brought in her own pain medication for him. Pt states that she gave him 10mg of Oxycotin. Nursing pain assessment for Monday night is 0 in point click care for the night patient reports this breakthrough pain. Pt is also requesting four tablets of Colace every other day to have scheduled bowel movement as he doesn’t want to be going to the bathroom every four hours because he says it just wont happen. He states he would rather go every other day. He refuses Colace every other day but needs four tablet every other night to produce this scheduled bowel movement every other day.