Home Health Quality Reporting Program (QRP) Training Case Study

Hospital Discharge Summary:
Mr. W is a 66-year-old man who lives independently with his wife in a two-story, single-family home. While visiting friends out of town, Mr. W fell, injured his back, and was transported emergently to the local acute care hospital. During his hospitalization in the acute care facility, he demonstrated confusion and, when questioned, indicated he was suffering ill effects from the pain medication he was receiving.

Mr. W became acutely agitated, and providers suspected alcohol withdrawal. He was intubated for airway protection. Mr. W remained intubated for 3 days and was noted to have loss of movement in his lower extremities. When his respiratory status improved, he was extubated. The patient's blood cultures returned positive for *MSSA* bacteremia, and his sputum cultures were positive for *E. coli*. He was treated with cefazolin and levofloxacin. A repeat MRI revealed a fluid collection in Mr. W's spinal canal, which was suspicious for hematoma and the possible source of the bacteremia. This was the likely cause of his back pain.

Mr. W suffered acute kidney injury and elevated liver function tests (LFTs) from alcoholic hepatitis. He was discharged with the following diagnoses: epidural abscess, *MSSA* bacteremia, hepatic encephalopathy, alcohol withdrawal, hypertension, diabetes mellitus type 2, lower extremity weakness, and neuropathy. He has no known drug allergies and was discharged on an NCS (no concentrated sweets) Diet. Vital signs remained stable over the past week: BP 135/92, P 78, RR 20, O2 98% on room air, Pain Scale score 4 out of 10.

Physical Therapy Discharge Summary:

- Mr. W requires assist of one from sit to stand.
- Mr. W requires assist of one to stand pivot to wheelchair
- Mr. W is able to ambulate 75 feet with a rolling walker and contact guard.

Occupational Therapy Summary:

- Mr. W requires setup and minimum to moderate assistance for all personal care activities.
- Mr. W requires setup for meals, but he can independently feed himself.

Prior Level of Function: Prior to the acute care admission, Mr. W was independent for all activities of daily living (ADLs) and did not use any assistive devices or aids.

Excerpt From the Home Health Agency (HHA) Nursing Start of Care Comprehensive Assessment:
The Home Care Agency received a referral for nursing, physical and occupational therapies, and home health aide services for Mr. W, who returned home following a 4-week acute care hospital stay. Mr. W's admission nursing assessment was completed the day after discharge. He was alert and oriented. The nurse noted that he spent most of his time on the couch on the first floor. Vital signs: BP 140/90, P 82, RR 18, O2 99% on room air. The nurse asked Mr. W to remove his slippers and measured his height using a paper tape measure that she taped to the door in his bedroom. Mr. W's height was recorded as 69.5 inches. She then weighed Mr. W and recorded his weight as 220.3 lbs.

Upon further assessment, the nurse noted that Mr. W's speech was clear, but he had difficulty finishing thoughts and occasionally finding words. Mr. W uses glasses for reading but frequently refuses to wear them. His wife, who was present during the admission, brought his eyeglasses to him. The patient reported a Pain Scale score of 6 out of 10, most intense in the lower back area, which increased to a pain score of 8 with movement and turning.

During the skin assessment, the nurse noted two healing scabs on the left side of Mr. W's nose and the lateral left side of his knee, along with scattered bruising on the left flank. She also noted that he has a 2 cm × 1 cm × 0.1 mm reddened area over his coccyx, with a 0.5 cm serum-filled blister in the center of the reddened area, and no indication of bruising, bogginess, or other indications of deep tissue damage. This was assessed as a Stage 2 pressure ulcer. After reviewing the discharge notes from the acute care facility, the nurse could not find documentation of the Stage 2 pressure ulcer.

His lower extremities were cool to the touch with little hair noted, and weak pedal pulses bilaterally. Mr. W reported that he normally has control of his bowels and urination, but over the last week he has experienced frequent loose stools, and on two occasions he did not make it to the bathroom in time. Lying to sitting on side of bed was assessed. The nurse noted that it was necessary for Mr. W's wife to support his trunk and lift his legs over the edge of the bed, providing more than half of the effort to assist him to the sitting position. In collaboration with Mr. W and his wife, and considering Mr. W's prior mobility status and motivation to improve, the nurse determined that Mr. W is expected to perform the activity of lying to sitting on side of bed independently by discharge. The patient was observed to safely ambulate with a rolling walker and stated that he has needed some help with ADLs from time to time.

Mr. W is prescribed a diabetic diet. His wife stated that Mr. W's doctor recently diagnosed him with diabetes. The nurse also performed the depression screening using the appropriate agency-accepted tool and determined that Mr. W does not have any risk factors at this time.

The nurse completed the medication reconciliation using the acute care discharge orders.

Oral medications include the following:

- Metformin 500 mg twice a day.
- Carvedilol 25 mg twice a day.
- Gabapentin 600 mg three times a day.
- Lactulose 1 tablespoon of 10 g/15 ml three times a day.

Mr. W showed the nurse a bottle of medication and stated that he takes Metoprolol 50 mg twice a day. The nurse considered this discrepancy a potential clinically significant medication issue, and his physician was contacted by telephone the same day the issue was identified to discuss and resolve outstanding patient care issues.

The following resolutions were reached:

- Physician confirmed that the patient should take Metoprolol 50 mg twice a day.

- Physician confirmed active diagnosis of diabetes mellitus type 2 on the hospital discharge summary.
- In response to the new Stage 2 pressure ulcer on the coccyx, the physician provided the following order: "Cleanse the wound with normal saline and apply a hydrocolloid dressing, change dressing every third day as needed if it becomes soiled."

Upon returning to the office, the nurse faxed the medication list to the physician. The following day, the physician signed and faxed the medication list back to the nurse. The nurse initiated these orders the same day she received the fax. The Metoprolol 50 mg twice a day was reordered and the medications and diet for diabetes were confirmed and continued. The nurse discussed these orders with the patient and his wife. The nurse also initiated the pressure ulcer regimen as prescribed by the physician.

Excerpt From the HHA Physical Therapy Evaluation:
The next day, the physical therapist arrived to assess Mr. W. The therapist noted that the patient uses a rolling walker, and his gait was slow while walking for 50 feet. He also required cueing to pick up his feet clear of floor. Balance measurements sit-static normal, sit dynamic normal; stand static fair. Transfer sit/stand technique reviewed, gait training reviewed, Home Exercise Program established. Mr. W complained of calf pain with ambulation (Pain Scale score 6 out of 10) and fatigue with shortness of breath. A ramp was recommended for the front steps into the house. However, his wife commented that they could not afford either rental or construction of a ramp stating, "I don't know how I will get him to the doctor next week, because I don't drive and can't lift him down the steps." The physical therapist contacted the nurse case manager to discuss the need for further evaluation by the clinical social worker.

Excerpt From the HHA Occupational Therapy Evaluation:
The occupational therapist evaluated Mr. W 2 days after discharge from the hospital.

- Mr. W requires setup with minimal to moderate assistance for personal care activities.
- For showering, he requires hands-on assistance, and a shower bench has been ordered.
- Mr. W can dress his upper body independently, but requires hands-on assistance for lower body dressing.
- He is independent in eating, after setup.

Excerpt From the Nursing Discharge Comprehensive Assessment:
Mr. W was on service for 6 weeks, and then refused further care. He received skilled nursing services 3 times per week and physical and occupational therapies 2–3 times per week.

At discharge, the RN assessed that Mr. W was able to move from lying to sitting on side of bed independently. Gait had improved to quad cane with contact guard, 75 feet. No additional medication issues were identified during the episode of care. The pressure ulcer on the coccyx was noted to be entirely covered with slough. Both Mr. W and his wife were instructed to follow up with his physician within 1 week for a wound evaluation. The patient was continent of bladder and bowel and independent in toileting. The physician was notified by phone of the patient's request for discharge and the need for follow-up related to wound care within 1 week.