University of Utah Health Sciences Interprofessional Education Simulation

Summary of Patient Hospitalization

Stroke Scenario
Spring 2019

FINAL DISCHARGE AND PATIENT INSTRUCTIONS
UNIVERSITY OF UTAH COLLEGE OF NURSING
LEARNING RESOURCE AND SIMULATION CENTER

SALT LAKE CITY, UT 84112-5880

Addressograph (simulated patient name/DOB here)

Admission Date_6 weeks ago_ Discharge Date _two days_ Service __PMR_

REASON FOR ADMISSION (Diagnosis, procedure, etc.): Left sided CVA with paralysis
DISCHARGE DIAGNOSIS: Ischemic CVA with residual paralysis right extremities, mild expressive aphasia, HTN

Principal Diagnosis	Left ischemic CVA
Other Diagnosis	Hypertension, hypercholesterolemia, depression, obesity
Surgical Procedure	

DISCHARGE STATUS: _X_ Home ___Skilled Nursing Facility ___Home Health Service ___Other
Diet: __X___Regular __Yes___ Restrictions: _Decrease intake of saturated fat and Cholesterol manage overall calorie intake to promote weight loss_____
Activity: _X_ As Tolerated _NO_ Restrictions: __**Follow Up Labs**: _____ **Lab Results to**: _____

Follow-Up Appointments				
Provider	**Clinic Name**	**Date**	**Time**	**Phone #**
Clinical Staff	Neurology	2 months		(801) 555-0000
Office Visit	PMR	1 month		(801) 555-0000
Office Visit	Nutrition Services	1 month		(801) 555-0000
Smoking Cessation	Primary Care			(801) 555-0000

TREATMENTS/SUPPLIES/ADDITIONAL ORDERS
__X_Physical Therapy Eval and Treat __X__Occupational Eval and Treat _X_Speech Eval and Treat
__X_ Recreational Therapy Eval and Treat __X__ Audiology Eval and Treat _X_ Nutrition Eval and Treat

Foley catheter (remove, continue, etc.) _____N/A__ Finger Stick Glucose (frequency) ___N/A____
Wound Care _____ Oxygen (flow rate) _____N/A_____

If you should have ANY of the following symptoms call you **Primary Provider IMMEDIATELY**:
Fever above 101 degrees --- Chest Pain Prolonged headache --- Shortness of Breath
New or progressing paralysis or paresthesia

OTHER PATIENT INFORMATION
_X_ Additional Education Materials (RN fills out) _____
I have been informed and have received the above discharge instructions, information and separate medication list. I have no questions regarding them.
Patient/Significant Other: _____ Relationship: _____ Date: _____

I have reviewed the above information and attached medication list with the patient/significant others who demonstrate understanding. Patient instructed to bring discharge instructions and medication list to next clinic appointment. These have been sent to the next provider of care.
RN Signature _____ Date: _____ Time: _____

Provider's Signature _____ Date: _____ Time: _____

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DISCHARGE MEDICATION RECONCILIATION AND DISCHARGE MEDICATION ORDER FORM

UNIVERSITY OF UTAH COLLEGE OF NURSING
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SALT LAKE CITY, UT 84112-5880

Addressograph (simulated patient name/DOB here)

New Medication ALLERGIES identified this admission _X__ None or _____

Prescriber must check one of these:

___ **Patient to continue ALL pre-admission Medications at the same dose** (no need to complete first two sections below)

(Provider to print copy of Medication Reconciliation Form, review and sign. Add **new** medications to the bottom)

RN to give this form and copy of Medication Reconciliation Form which has been reviewed and signed by provider to patient.)

_X__ **Patient's medications have been adjusted or patient is being discharged to a SNF**

(Prescriber to complete orders below. Patients discharging to SNF must have all medications written)

PATIENT IS TO STOP THESE PRE-ADMISSION MEDICATIONS		
Medication		**Reason for Stopping**
Generic Name	**Brand Name**	

PATIENT IS TO CONTINUE ONLY THES PRE-ADMISSION MEDICATIONS						
Medication Name (include prescription and OTC)		**Medication Changed from Pre-Admit**	**Dose/ Strength**	**Route**	**Frequency** (do not abbreviate)	**Next Dose** (RN fills out date and time)
Generic Name	**Brand Name**					
Acetaminophen	Tylenol	No	500 mg	Oral	Every 4 hours as needed for pain	
Lisinopril	Zestiril	No	20 mg	Oral	Once daily	

PATIENT IS TO BEGIN THESE NEW MEDICATIONS (Controlled substances must be written below and on a separate prescription.)					
Medication Name		**Dose/ Strength**	**Route**	**Frequency**	**Next Dose** (RN fills out date & time)
Generic Name	**Brand Name**				
Aspirin	Aspirin	325 mg	Oral	Once Daily	Tomorrow morning
Zanaflex	Tizanidine	2mg	Oral	Once daily	
Lipitor	Atorvastatin	80 mg	Oral	Once daily	
Hyzaar	Losartan, HCTZ	100-12.5 mg	Oral	Once daily	
Prozac	Fluoextine	20 mg	Oral	Once daily	

Date	Time	Signature	Printed Name	DEA #
today	1400	J. Doe, MD	John Doe, MD	XXXXXXX

Discharge Note

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SALT LAKE CITY, UT 84112-5880

(simulated patient name/DOB here)

Summary of Hospitalization:

The patient is a 66 y. o. male, admitted into the hospital for acute ischemic stroke, L MCA territory. NIHSS admit 16. Patient was OOW for TPA. Patient experienced a left sided CVA with residual partial paralysis of the right side and mild expressive aphasia. PMH: mild hypertension. No major illness prior to the stroke. Pre-mRS 0.

Neurology, PT, OT, Recreational Therapy, Audiology, Speech, Nutrition, and Social Work were consulted. The patient had multiple imaging studies, pertinent for acute stroke. Patient was admitted to NICU (1 day) and NCC for 2 days. Patient was discharged to acute inpatient rehabilitation for PT, OT, Recreational Therapy, Speech, Psych, Social work services. Patient has completed 5 week stay in IRF and is ready for DC to home per recommendations from team. Pt will be discharged with outpatient services.

Allergies: no known

Neuro: awake, alert, and oriented to person, place, and time. Right upper extremity weak grossly 2/5, Left 5/5 strength, Left lower extremity grossly 5/5, right lower extremity 4/5 strength. Ashworth finds upper extremity 1, Lower extremity 2 with extensor tone.

CN II-XII: intact, EOMI.

CVP: pulse 72, blood pressure 110/62; respirations 16. Lung sounds clear to auscultation. O2 Sat on room air = 98%. Peripheral pulses and good cap refill.

GI: Abdomen soft, non-tender, distended, + bowel sounds. Bowel movement every other day.

GU: Voids freely requiring assistance to the commode/bathroom. Output approximately 1000ml/day. Brief episode of dysuria on admission.

Integumentary: Braden Score – consistently 15-18 indicating mild risk for skin breakdown due to mobility issues, when in the hospital. Skin integrity was monitored and interventions to prevent breakdown instituted daily. No concerns at this time.

Musculoskeletal: Left shoulder subluxation 1 finger, painful with abduction, external rotation.

Psychosocial: lives with supportive spouse in a ranch-style home; occupation: Consultant; patient was independent with BADLs & IADLs prior to admission.

Diagnostic studies: CXR, EKG, MRI upon admission. Contract venography.

Functional status: OTC AFO, SPC for mild foot drop. Some knee hyperextension, trendelenberg. No falls, educated on fall risk and safety precautions. Speech some hesitating and stumbling to find words, but can make himself understood.

DISCHARGE NOTES

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(simulated patient name/DOB here)

Social Work Assessment:

Mr. Smith is in recovery from a recent stroke and has reported a family history of high blood pressure and stroke.

Psych: Mr. Smith presented as alert and attentive. Able to make good eye contact and his affect was consistent with his mood. Recently had a stroke and it is recommended that he should be screened regularly for other mental health issues commonly associated with a stroke such as post stroke depression. Oriented X3 and his thought process was lucid. Mild expressive aphasia noted.

Social: Mr. Smith is a retired consultant. Reports living with spouse in a ranch style home. Reports the house in not yet paid for and there is some concern about being able to make the mortgage payments. Expressed a desire to be independent again.

Occupational Therapy Assessment:

Mr. Smith experienced a left sided CVA with residual partial paralysis of the right side and mild expressive aphasia, mild hypertension. The chief complaint is weakness of the right side, trouble speaking and backaches.

Prior to Admission: Mr. Smith lives in a ranch home with 4 steps to enter. The bedroom, kitchen and living areas are on the main floor but the laundry room and office are in the basement. Lives with spouse who is out of the home several times a week for social events. Prior to admission, he was independent walking without an assistive device and independent with ADL's. Mr. Smith worked as a consultant and is currently retired.

Cognition/Language: Mr. Smith is alerted and oriented x3. Functional cognitive screening indicates minimal assistance with medication management and household safety. No further cognitive testing has been done at this time. Mild expressive aphasia noted.

Sensory/Perceptual: Does not present with any sensory or perceptual deficits. He wears bifocals and reports preferring large print. PROM of RUE and RLE is WFL. Right-hand dominant.

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(simulated patient name/DOB here)

Functional Status: Requires minimal assistance to dress upper and lower body. Moderate assistance with fasteners. Modified independence with showering and grooming. CGA for toilet and shower transfers.
Motor Control:
Voluntary Movement: Normal in L extremities

RUE: Subluxation of L shoulder, but can reduce with shoulder shrug. Mass grasp present and mild flexion synergy present when asked to move arm. No fine motor skills and limited grip strength.

Physical Therapy Assessment:

Mr. Smith experienced a left sided CVA with residual partial paralysis of the right side and mild expressive aphasia, mild hypertension. The chief complaint is weakness of the right side, trouble speaking and backaches.

Prior to admission He was independent walking without an assistive device and independent with ADL's. He lives in a ranch-style home with 4 steps to enter and a flight of stairs to get to the basement. Lives with his spouse who is out of the home several times a week for social events. No significant past medical history

Cognition/language: Patient is oriented X3. Gross evaluation indicates memory, attention is WNL. Mild expressive aphasia noted.

Cardiopulmonary status: Lungs are clear and 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 L extremities

RUE: Subluxation of L shoulder, but can reduce with shoulder shrug. Mass grasp present, and mild flexion synergy present when asked to move arm. no fine motor skills and limited grip strength.

RLE: 4/5 in hip, 4/5 knee, 1/5 dorsiflexion, 2/5 plantar flexion, extension synergy pattern noted.
Balance: Sitting: able to maintain independently. Standing: loses balance with moderate displacement or active movement.
Functional activities:
Supine -> sit: supervision

Sit -> supine: supervision
Stand pivot transfer: supervision
Standing: CGA
Ambulation: OTC AFO, decreased stance on L. CGA on even surfaces. Min assist for stairs, thresholds and uneven surfaces

Recreational Therapy Assessment:

Mr. Smith is a 66-year-old white male, who experienced left-side CVA 2 months prior to this assessment and is preparing for discharge to home.

Physical: Partial paralysis of the total right side. Client is predominantly right-handed and demonstrates significant loss of fine motor skills in the right hand, which appeared to create frustration when attempting to complete assessment activity.
CERT-PD-Gross Muscular Function-14 slightly below average with right upper extremity and endurance showing limitations.
Fine Motor-5.5-below average with right side limitations
Locomotion-6-average with assistance
Motor Skills-5-below average with right side limitations in fine motor, reaction time, gross motor and some balance instability.
Social: Client reports spouse as a major support system. He noted two friends who have visited frequently since hospitalization and both have voiced a desire to help. Mr. Smith also considers his neighbor and sister as individuals in his support system.
Emotional: Client disclosed some feelings of helplessness and questioned his ability to return to work or return to his normal routine. He did become tearful when he discussed the burden he is placing on his wife.
Cognitive: Client expressed uncomfortableness with his inability to express himself verbally. He does appear to limit some social conversation due to his mild expressive aphasia. Client shows no cognitive delay in following 3-step directions and was able to recall instructions throughout assessment activity.
Spiritual: Client reported no religious affiliation and at this time is questioning his overall life purpose. He enjoys the outdoors and stated he finds peace in the quiet moments of a sunset.
Leisure Interest: Client identified reading, watching TV, and working in his garden as his current leisure interests. He discussed past interest in fishing and camping but has not participated in these types of activities for the past 10 years. He also reported he has few physical activities and is primarily a spectator.
Idyll Arbor Leisure Battery Scores:
LAM: Client is not currently engaged in a variety of healthy leisure activities and could use additional information on leisure and the direct relationship to quality of life.
LSM: Client will need additional knowledge and competence in adaptive devises for recreation involvement.
LMS: Client scores reflect higher motivation in leisure engagement if he is involved in learning or exploring something new and intellectually stimulated. He also uses leisure

activity to calm or relax (stimulus-avoidance).

LIM: High Scores: outdoor, social, mechanical
Low Scores: physical, artistic

Audiology Assessment:

Mr. Smith, age 66, experienced a stroke 6 weeks earlier. He is seen today for hearing re-evaluation and hearing aid troubleshooting. Patient was diagnosed with a mild sloping to severe sensorineural hearing loss, bilaterally in 2012 and fit with binaural amplification. Presents today with concerns that he is not hearing as well as before his stroke, is experiencing tinnitus, and is having difficulties putting in his hearing aids and adjusting them due to weakness on right side.

Otoscopy: Clear ear canals, bilaterally
Tympanometry: Type A tracings, bilaterally indicative of normal middle ear pressure and compliance.

Acoustic Reflex Thresholds: Elevated thresholds at 500 Hz in the ipsilateral condition, bilaterally. ARTs absent at 1000 Hz and 2000 Hz, bilaterally in the ipsilateral condition. ARTs absent in the contralateral condition at 500 Hz, 1000 Hz, and 2000 Hz, bilaterally.

Pure tone testing: Mild sloping to severe sensorineural hearing loss, bilaterally. No change in hearing thresholds since last evaluation in 2017.

	250 Hz	500 Hz	1000 Hz	2000 Hz	3000 Hz	4000 Hz	6000 Hz	8000 Hz
RE AC	30 dB HL	35 dB HL	40 dB HL	50 dB HL	55 dB HL	70 dB HL	75 dB HL	80 dB HL
RE BC		30 dB HL	40 dB HL	50 dB HL	50 dB HL	70 dB HL	75 dB HL	
LE AC	35 dB HL	40 dB HL	40 dB HL	55 dB HL	65 dB HL	75 dB HL	80 dB HL	85 dB HL
LE BC		40 dB HL	40 dB HL	55 dB HL	60 dB HL	75 dB HL	75 dB HL	

Visual Inspection Hearing Aids: Aids were clean with no evidence of damage to the exterior.
Listening check (Both): Good sound quality.
Actions Taken: Cleaned Both hearing aids. Replaced wax guards. Both hearing aids. Programming adjustment (Both). Increased gain globally 3 dB.
Tinnitus evaluation: Tinnitus Handicap Inventory (THI) administered and patient scored 22, indicating Mild Handicap.

Counseled on communication strategies and reviewed care and maintenance of the hearing aids.

Speech-Language Pathology Assessment:

Mr. Smith, age 66, experienced a left sided ischemic CVA in the left MCA territory with residual partial paralysis of the right side and mild hypertension. The chief complaint is weakness of the right side, trouble speaking and backaches.

Prior to admission: He worked as a consultant and is currently retired. Patient reports no prior history of speech, language, cognitive or swallowing difficulties, however he has a history of mild sloping to severe sensorineural hearing loss, bilaterally for which he uses bilateral hearing aids. Currently, he needs assistance with his hearing aids due to right sided weakness.

Respiratory status: Per previous notes, lung sounds were clear to auscultation and O2 Sat on room air was 98%.

Clinical swallow assessment:

Oral-Motor examination: ROM and strength of lips and jaw WFL. Slight R deviation of tongue on protrusion. Tongue strength (ability to resist pressure on tongue with tongue depressor) mildly reduced on protrusion and lateralization. Pt. reports biting tongue on R on occasion. Strong volitional cough. Adequate, symmetrical, velar excursion on initial and repetition of “ah.” Sustained phonation for “ah” was 12 seconds (average =10 – 15 seconds). Vocal quality and resonance WFL.

PO Trials: Trials conducted with thin (3 oz. of H2O), nectar-tick (Boost) and pudding-thick (vanilla pudding) liquids and solid (cracker) consistencies. O2 Sat monitored throughout and for two minutes following PO trials. Oral phase: Adequate lip closure for all consistency trials. Adequate bolus control for thin, nectar and pudding thick trials with slight difficulty clearing residue with tongue between cheeks and gums bilaterally--L more difficulty than R on solid (cracker) trials. Pharyngeal phase: Swallow initiation well timed with brisk hyolaryngeal excursion on all trials. No significant pharyngeal residue observed following initial swallow on any consistency. No signs/symptoms of laryngeal penetration/aspiration (i.e., “wet” voice, coughing) on any trials. O2 Sat ranged from 97% - 98% during and for 2 minutes following PO trials.

Impression: Mild oral dysphagia due to tongue paresis. Patient can tolerate a regular diet. Moistening dry foods is recommended to aid bolus formation.

Cognitive/language/speech assessment (informal):

Patient wore his hearing aids during this assessment. Cognition: Mr. Smith was oriented X3 and he was able to answer questions about his career and family accurately (confirmed by spouse) suggesting functional attention and short and long term memory. Auditory Comprehension: Patient pointed to 10/10 common objects and pictures in the hospital room, answered 5/5 egocentric yes/no questions, 5/5 general yes/no questions and accurately followed 5/5 complex (three-part) commands. Expression: Intact automatic speech and repetition of single words and phrases. Patient named pictures with 6/10 accuracy. Errors included semantic paraphasias and one no-response. Word retrieval/anomia also was noted in patient's spontaneous speech; however, he was generally able to convey messages given adequate time. He used circumlocution when unable to retrieve specific words. Patient occasionally self-corrected his semantic paraphasias. Mr. Smith expressed frustration regarding difficulties with verbal expression particularly related to the effect on his/her ability to interact with family, friends and medical providers following discharge. Reading/Writing: Patient read a short paragraph and answered 5/5 yes/no comprehension questions accurately. He/she wrote three short sentences to dictation with left (non-dominant) hand. Handwriting was labored but accurate and legible. Speech/articulation: Patient's speech was intelligible. Rapid alternating motion rates were WNL for /pa/ and slightly reduced for /ta/ and /ka/ (likely due to minimal tongue paresis).

Impression: Mild expressive (primarily anomic) aphasia.

Counseled patient and spouse regarding strategies to improve verbal expression and word-retrieval. Recommended outpatient speech-language therapy.

Nutrition Assessment:

Mr. Smith experienced a left sided ischemic CVA 6 weeks ago and is scheduled to be discharged. Past medical history of hypertension. Patient was seen today to discuss management of hypercholesterolemia and weight loss. Pt stated still feeling challenged while eating with non-dominate hand, however getting better. Patient states no known allergies and intolerances. Pt states wife grocery shops and prepares the majority of the meals, however he enjoys grilling. Prior to hospitalization patient would eat 3-4 meals per week at a restaurant. Patient has minimal education on high cholesterol. Patient has attempted weight loss in the past being able to lose approximately 20 pounds but nothing worked long term.

Ht: 73 inches

Wt: 285 (typical weight 280)

BMI: 37.6

Diet Recall: Typical diet prior to hospital admission

Breakfast: Toast, 2 eggs, 2 strips of bacon or sausage, OJ and coffee with non-dairy creamer

A.M. Snack: 2-3 Pastry and cola

Lunch: Sandwich with deli meat and cheese, mayo and mustard, pickle, potato chips, apple, water

PM Snack: pretzels and cheese, cola

Dinner: steak, large baked potato with butter, sour cream, bacon bits, small side salad with ranch dressing, sweetened ice tea or occasional glass of red wine (3-4x per week)

Evening Snack: ice cream with chocolate sauce, cookies, cake or brownies.

Patient states that if he had trouble sleeping he would often have a late night snack of pretzels or chips while watching TV.

Physical activity: does not engage in regular physical activity but did enjoy being outside gardening or sometimes going for an evening stroll with his wife in the summer months.

Kcal recommendation: 1600-1800 kcals to promote weight loss of 1 pound/week

Nutrition Diagnosis (PES): Hypercholesterolemia and obesity related to excessive intake of saturated fat, cholesterol and total calories as evidenced by dietary recall and BMI.

Readiness to Change: Moderate patient expressed desire to change diet and lifestyle to better manage health but states that he feels ‘very overwhelmed with all the changes’.

Patient was counseled on diet strategies to manage cholesterol, achieve long term weight loss, increase fruit/vegetable/whole grain consumption, and encouraged to increase physical activity as able. Patient agreed to follow-up appointment 1 month post discharge.