AQ-IQ IRF PRO LAB

Case 8, Class 4

Coder Summary

Patient Four

DRG: 065 Intracranial hemorrhage or cerebral infarction w CC or tPA in 24 hrs

Admitting Diagnosis:

I62.01 Nontraumatic acute subdural hemorrhage

Principal Diagnosis:

I62.01 Nontraumatic acute subdural hemorrhage (DRG)

Secondary Diagnoses:

G20 Parkinson's disease

F03.90 Unspecified dementia without behavioral disturbance

I10 Essential (primary) hypertension

Ell.65 Type 2 diabetes with hyperglycemia

I69.251 Hemiplegia fol oth ntrm intcrn hemor aff right dominant side (Ce)

N40.0 Enlarged prostate without lower urinary tract symptoms

R56.9 Unspecified convulsions

K59.00 Constipation, unspecified

D62 Acute posthemorrhagic anemia (Ce) (DRG)

I69.81 Cognitive deficits following other cerebrovascular disease

G89.18 Other acute postprocedural pain

R49.0 Dysphonia

R51 Headache

Pre-Admission Screening:

IGC: 2.1

Etiology: Subdural hematoma

Date of screening: 8/11/19

Patient is a 79 year old right handed male with a history of Parkinson's disease, who has had progressive right-sided weakness, gait abnormalities for the past month or 2. The patient underwent CT of the head which revealed a complicated acute on chronic left nontraumatic subdural hematoma with 6 mm left to right midline shift. The patient was evaluated by Dr. K- and underwent craniotomy with hematoma evacuation on August 1st. Hospital course was complicated by severe headache, vomiting and elevated blood pressures. He returned for second craniotomy on August 8th. He remains with a drain in place.

Complications include: right hemiparesis, dysarthria, possible dysphagia, impaired mobility and ADLs, gait abnormality, Parkinson's disease, postoperative pain, constipation, dementia, hypertension, type 2 diabetes and benign prostatic hypertrophy.

ADMISSION GG SCORE: 30

Post-Admission Note

DATE OF ADMISSION: 08/11/2019.

REASON FOR ADMISSION: Acute on chronic nontraumatic left subdural hematoma status post craniotomy and evacuation times 2, impaired mobility, ADLs, gait abnormality and Parkinson's disease.

HISTORY OF PRESENT ILLNESS: The patient is a 78-year-old right-handed Polish speaking male with a history of Parkinson's disease, who has had progressive right-sided weakness, difficulties with speech and gait abnormalities. The patient had a CT of the head revealing a complicated acute on chronic left nontraumatic subdural hematoma with 6 mm of right midline shift. He underwent craniotomy with hematoma evacuation on 08/01/2019 with Dr. R_. During the hospital course, the patient had severe headaches and vomiting with elevated blood pressures. He returned for a second craniotomy and evacuation on 08/08/2019 with Dr. R_ There was concern for a postoperative seizure for which neurology was consulted and the patient was placed on Vimpat. He was also noted to have difficult to control blood pressures and blood sugars. He was able to participate with therapies and found to be below his functional baseline and thus admitted to acute inpatient rehabilitation.

PAST MEDICAL HISTORY AND MEDICAL COMORBIDITIES: Parkinson's disease, dementia, hypertension, type 2 diabetes, BPH, left subdural hematoma and possible seizures.

FAMILY HISTORY: Reviewed and noncontributory to this admission.

CURRENT MEDICATIONS: Flomax 0.4 mg at bedtime, lisinopril 5 mg daily, Tylenol No. 3 as needed, amlodipine 10 mg daily, Senokot two tablets daily, Tylenol as needed, Sinemet 25/100 mg t.i.d., Colace 100 mg b.i.d., Vimpat 50 mg b.i.d., metoprolol 25 mg q. 12 hours, Advair q. 12hours, Dulcolax suppository as needed, nortriptyline 25 mg at bedtime, MiraLax one packet daily, glipizide 10 mg daily, metformin 1000 mg b.i.d., and Humalog insulin sliding scale.

ALLERGIES: No known drug allergies.

SOCIAL HISTORY: The patient lives with his wife in a second story apartment but does have a stair lift. He denies any tobacco or alcohol use.

PRIOR LEVEL OF FUNCTION: The patient was ambulating within the home without an assistive device and was independent for basic ADLs. His wife occasionally assists with dressing and also assists with IADLs.

CURRENT LEVEL OF FUNCTION: Transfers min assist, toileting dependent, upper body dressing max assist, lower body dressing dependent, bathing max assist.

REVIEW OF SYSTEMS: Positive for mild headache, difficulty sleeping and constipation. The patient denies any fevers, chills, chest pain, shortness of breath, abdominal pain, nausea, vomiting, bladder issues, extremity numbness, tingling or focal weakness. Complete 12-point review of systems otherwise unremarkable.

PHYSICAL EXAMINATION: Vital signs, temperature 97.6, pulse 76, blood pressure 117/60, respirations 18, and oxygen saturation 94% on room air. In general, he is a well-developed and well-nourished male in no acute distress. He is alert and oriented to person, place, and situation.

HEENT: He has a large left craniotomy incision with staples in place. There is mild swelling and tenderness to palpation. Extraocular muscles are intact.
Cardiovascular: SI, S2.
Lungs: clear to auscultation bilaterally.
Abdomen is soft, nontender, nondistended with present bowel sounds.
Extremities are without edema.
Neurologic exam: strength is grossly 5/5 throughout all extremities. Fine motor coordination is impaired in the right hand. Sensation is intact and symmetric to light touch. Babinskis are negative. Cranial nerves II-XII are grossly intact.
He does not appear to have any resting tremor or cogwheeling of the wrists.
Skin: his craniotomy incision is clean, dry and intact with staples in place. Otherwise, skin appears intact.

LABORATORY: Sodium 135, potassium 3.9, chloride 101, bicarb 22, BUN 7, creatinine 0.71, glucose 197, white blood cells 8.6, hemoglobin 11.2, hematocrit 33.2, and platelets 469.

ASSESSMENT: This is a 79-year-old male with left acute on chronic nontraumatic subdural hematoma, status post evacuation on 08/01/2019 followed by repeat evacuation on 08/08/2019 with Dr. R_; Parkinson's disease; impaired mobility; activities of daily living; cognition; gait abnormality; postoperative pain and headache; possible seizure, constipation; active type 2 diabetes; hypertension; and anemia secondary to blood loss.

PLAN:

1. The patient will be admitted to acute inpatient rehabilitation for comprehensive therapies including PT, OT, speech therapy and 24-hour rehab nursing. Physical therapy will address lower extremity strengthening, endurance, bed mobility, gait, balance, transfer, and stair training. Occupational therapy for upper extremity strengthening, ADLs, FMC, and use of adaptive equipment. Speech therapy for assessment of cognition. A 24-hour rehab nursing for monitoring his pain and incision, skin, establishment of bowel and bladder program as well as education on medical issues and assistance with carryover of therapies. Dr. E_ will continue to follow to assist with medical needs. Risks and barriers include risk for reaccumulation of the hematoma, seizures, intractable headache, uncontrolled diabetes and hypertension and risk for falls due to gait abnormality.

1. Neurology issues. Continue Sinemet dosing for Parkinson's disease.
   Continue Vimpat for seizure prophylaxis per the neurology team. We will need to clarify the duration of treatment.
2. Pain. Continue Tylenol and Tylenol No. 3 as needed. He is also receiving nortriptyline for headaches.
3. Bowel and bladder. Continue Colace, Senokot, MiraLax, and suppository as needed for constipation. Continue Flomax for BPH. Nursing to establish bowel and bladder program.
4. Diet. Diabetic diet.
5. Skin. Nursing to monitor incision site and for signs of skin breakdown.
6. DVT prophylaxis. Continue SCDs and ambulation. We will not begin any chemoprophylaxis due to the subdural hematoma.
7. Active type 2 diabetes. Continue metformin and glipizide with insulin sliding scale as needed. Dr. E_ will continue to follow to assist with management.
8. Hypertension. Blood pressures appear controlled with lisinopril, amlodipine, and metoprolol.

Continue to monitor for elevations i n blood pressures that could also indicate acute underlying

neurologic abnormality.

9. Anemia secondary to blood loss. We will repeat a CBC in the morning to monitor trends.

Preadmission screening was reviewed and the patient is an appropriate candidate for acute inpatient rehabilitation and requires comprehensive medical management in addition to inpatient PT, OT, ST and 24-hour rehab nursing.

There have been no significant changes in functional status, medical condition or discharge plan. The patient is motivated and able to tolerate 180 minutes of therapy a day at least 5 days a week with goal of discharging home with his wife at a modified level of independence for gait and basic ADLs. Rehab potential is good.
The estimated length of stay is 2 weeks.

Progress Note

Date: 8/15/2019

S: Pt report, he is doing ok today. He denies any HA currently, but wife notes he had one yesterday while family was visiting. Pt notes voice hoarseness- wife reports pt typically takes baclofen when this happens & attributes it to PD. Denies any dysphagia

PE:
T 98 P 79 R 18 BP 124/62 02 97% on RA
Gen: NAD, Alert
HEENT: NC/at crani site with staples
CV: Sl,S2
Lungs: CTAB
Abd: soft, nr/nd, BS+
Ext: no edema.

Therapy Progress: Amb CGA w/SC, stairs minA, transfers minA Goals modi.
Medication list reviewed & updated. Labs:

A/P:

I. Rehabilitation: Left acute on chronic nontraumatic subdural hematoma s/p evacuation 8/1 and 8/8, with Dr. A_. Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont sinemet for PD.
2. Cont Vimpat for seizure ppx per Neurology. Will repeat CT head monday
3. to f/u SDH. Dr. A_following.
Pain: Tylenol & Tylenol #3 pm, nortrip1ylinc for 1-f.t\.
4. Bladder & Bowels: Colace, senokor, mirnlax, suppository pm for
5. constipation; will change senna to pm per wife request. Flomax for BPH.
6. Nursing for bowel/bladder program.
7. Diet: diabetic diet.
Skin: nursing to continue
8. monitor. DVT ppx: SCDs,
9. ambulation.
10. DM2: cont metformin, glipizidc, ISS. Will add lantus at bedtime as blood sugars remain elevated.

Appreciate Dr. E_ assistance.
HTN: cont lisinopril, amlodipine, metoprolol.
Anemia: 2* to blood loss. Cont to monitor
CBC. Dysphonia: will order baclofen pm
per wife's request. Dispo: anticipated
d/c 8/25.

Progress Note

Date:
8/16/19

S: Pt is doing ok, reports minimal occasional HA Per wife, pr has had worsening of coordination of R hand over the past few days. Per nursing, pt's BP has been running low.

PE:
T 98 P 97 R 16 BP 100/60 02 97% on RA
Gen: NAD, Alert
HEENT: nc/at, crani site c/d/1 with staples
CV: S1,S2
Lungs: CTAB
Abd: soft, nt/nd, BS+ Ext: no
edema.
Neuro: strength 5/5 R hand grip, elbow flexion, extension, 4/5 R hip flexion, 5/5 knee extension, ankle DF/PF> Reduced FMC & motor planning of R hand

Therapy Progress: 8 stairs CGA standing tasks w/SC CGA. Goals modI
Medication list reviewed & updated.

Labs:

CT head: decreased thickness L frontal fluid, increased L parietal-

occipital fluid A/P:

1. Rehabilitation: Left acute on chronic non traumatic subdural hematoma s/p evacuation 8/1 and 8/8 with Dr. A_ Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont Sinemet for PD. Cont Vimpat for seizure ppx per Neurology. Will notify Dr. A_of CT head results & await recommendations.
2. Pain: Tylenol & Tylenol # 3 prn, nortriptyline for HA.
3. Bladder & Bowels: Colace, senokot, miralax, suppository pm for constipation. Flomax for BPH. Nursing for bowel/bladder program.
4. Diet: diabetic diet
S. Skin: nursing to continue to monitor.
6. DVT ppx: SCDs, ambulation.
7. Dr.i-2: cont. metformin, glipizide, lantus, ISS. Blood sugars improving with addition of lantus.
   Appreciate Dr. E_ assistance.
8. HTN: cont lisinopril, amlodipine, metoprolol. BPs running low- will d/ c amlodipine & reduce lisinopril dose. Monitor BP response.
9. Anemia: 2* to blood loss. *Cont* to monitor CBC.
10. Dysphonia: cont baclofen prn for spasms.
11. Dispo: anticipated d/c 8/25.

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Progress Note

Date
:
8/17/2019

S: Pt seen and examined in room with Dr. W_, Pt states he is feeling better today compared to yesterday. He has improved coordination of the R hand. He has mild headache which is improved overall. He slept well overnight. Per therapists, weakness tends to be worse in the evening when he is more fatigued.

PE:
T 98 P 74 R 18 BP 124/74 02 97%onRA
Gen: NAD, Alert
HEENT: nc/at, crani site
c/d/1 with staples
CV: S1,S2
Lungs: CTAB
Abd: soft,
nt/nd, BS+ Ext:
no edema.

Therapy Progress: *50'* x2 w/SC CGA,
grooming/hygiene- min A. Goals modI Medication list
reviewed & updated.

Labs:
CT head: decreased thickness; L frontal fluid, increased L parietal-occipital fluid A/P:

I. Rehabilitation: Left acute on chronic nontraumatic subdural hematoma s/p evacuation 8/1 and 8/8 with Dr. A_, Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont sinemet for PD. Cont Vimpat for seizure ppx per
2 Neurology. Will discuss pt's weakness with Dr. A_ and :any need for repeat imaging.
3. Pain: Tylenol & Tylenol #3 pm, nortriptyline for HA.
4. Bladder & Bowels: Colace, senokot, MiraLAX, suppository pm for constipation. Flomax for BPH Nursing for bowel/bladder program.
5. Diet: diabetic diet.
6. Skin: nursing to continue to monitor.
DVT ppx:
7. SCDs, :ambulation.
8. DM-2: cont. metformin, glipizide, lantus, ISS. Blood sugars improving with addition of lantus. Appreciate Dr. E_ assistance.
9. HTN: cont lisinopril, metoprolol. BP improved with d/c of amlodipine & decreased Lisinopril.
10. Anemia: 2'* to blood loss. Cont to monitor CBC. Dysphonia: cont baclopen pm for
11. throat spasms. Dispo: anticipated d /c 8/25.

Attending ,Addendum:
Pt seen & examined with NP; agree with above. Pt reports sleep is improving and denies any HA. His R hand function was improved yesterday with therapy, but tends to be worse when he is fatigued. Speak with Dr. A_ re: need for repeat CT head to f/u on posterior parietal collection. Pt now ambulating 50' w/SC CGA, goal modI. BPs improved with changes to meds yesterday.

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Progress Note

Date :
8/18/2019

S: Pt cont to note issues with R hand dexterity/coordination but appears to be worse upon awakening & when fatigued. He notes only minimal HA. Discussed CT results with pt & wife

PE:
T 98.5 P 98 R 18 BP 116/67 02 97% on RA
Gen: NAD, Alert
HEENT: nc/at, crani site c/d/I with staples
CV: S1,S2
Lungs: CTAB
Abd: soft, nt/nd,
BS+ Ext: no
edema.
Neuro: reduced FMC in R hand, strength 4+ /5 for hand grip & finger abduction, mild apraxia noted

Therapy Progress: 8 stairs with bilat HR SBA UE dressing SBA. Goals modI. Medication list reviewed &

updated. Labs:

CT head stable to a few millimeters decrease in size of L subdural hematoma

A/P:

1. Rehabilitation: Left acute on chronic nontraumatic subdural hematoma s/p evacuation 8/1and 8/8 with Dr. A Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing care. Cont sinemet for PD. Cont Vimpat for seizure ppx per Neurology. Repeat CT as above; per Dr. A, will cont to monitor for clinical changes.
2. Pain: Tylenol & Tylenol #3 prn, nortriptyline for HA
3. Bladder & Bowels: Colace, senokot, miralax suppository pm for constipation. Flomax for BPH. Nursing for bowel/bladder program.
4. Diet: diabetic diet.
5. Skin: nursing to continue to monitor.
6. DVT ppx: SCDs, ambulation.
7. DM-2: cont. metformin, glipizide, lantus, ISS. Blood sugars improving with addition of lantus. Appreciate Dr. E_ assistance.
8. HTN: cont lisinopril, metoprolol. BP improved with d/c of amlodipine & decreased Lisinopril.
9. Anemia: 2* to blood loss. Cont to monitor CBC.
10. Dysphonia: cont. baclofen pm for throat spasms.
11. Disposition: anticipated d /c 8/25.

Progress Note

Date
8/24/2019

S: Pt seen and examined in room with Dr. H_ Pt states he has a sore throat this morning he attributes to the weather. His wife is having the same symptoms. He denies any headache, fever, cough, chest congestion, sinus pain or pressure or rhinorrhea. He states he slept well overnight. He asks what time his staples can come out.

PE:
T 98.0 P 77 R 18 BP 122/68 02 92% on RA
Gen: N,\D, AOx3
HEENT: nc/at, crani site c/d/I with staples. Oropharynx with no signs of erythema, edema or exudate. CV: SI,S2
Lungs: CTAB
Abd: soft, nt/nd,
BS+ Ext: no
edema.

Therapy Progress: toileting: SBA, up and down 8 stairs with BL HR CGA/SBA Goals modI Medication list reviewed & updated.

Labs:

A/P:

1. Rehabilitation: Left acute on chronic nontraumatic subdural hematoma s/p evacuation 8/1 and 8/8 ,with Dr. A_ Parkinson's disease. Continue comprehensive PT, OT, ST & 24-hour nursing
2. care. Cont sinemet for PD. Cont Vimpat for seizure ppx per
3. Neurology. Dr. A_ available pm. Pain: Tylenol & Tylenol #3 pm, nortriptyline for HA
4. Bladder & Bowels: Colace, senokot, miralax, suppository pm for
5. constipation. Flomax for BPH. Nursing for bowel/bladder program.
6. Diet: diabetic diet.
7. Skin: nursing to continue to monitor. Per Dr. A_ will remove staples today. DVT ppx: SCDs, ambulation.
8. DM-2: cont metformin, glipizide, lantus, ISS. Blood sugars improving with
9. the addition of lantus.
10. Appreciate Dr. E_ assistance.
    HTN: cont lisinopril, metoprolol.
    Anemia: 2 * to blood loss. Hgb improving; monitor CBC.
    Dysphonia: cont baclofen pm for throat spasms. Will add cepacol throat lozenges for pain.

Discharge Summary: 8/25/19

Discharge diagnoses: left acute on chronic nontraumatic subdural hematoma status post evacuation x2, Parkinson's disease, right hand weakness and impaired fine motor coordination, impaired cognition, possible seizures, headaches, BPH, DM II, HTN, and anemia secondary to blood loss.

Discharge to home and will attend outpatient PT, OT and speech therapy.

IGC:

ETIOLOGIC:

TIER:

60% QUALIFIER:

COMMENTS:

