Case Studies
2017

Finding Your Lost Inpatients – 2 MN and Managed Medicare

Goal of great working lunch

- Review 2 cases/present 1 and discuss the case and all the 'other stuff' that could be occurring that impacts the decision:
  - Inpt from the ER
  - Convert to inpt – after the 1st outpt MN. Does the pt need one more clinically appropriate MN 'in hospital?"
  - Discharge – and what is making the discharge tough?
  - Delays & Complicating factors

#1 Case study (Table 1) Finding the inpt? Is it here?

- 68 year old man presents to the ED with several day history of urinary symptoms, vague intermittent abd discomfort, gassy and feverish feeling over the past several days and intermittent chills and nausea without vomiting. Pt on oral medications for constipation, hypertension, cholesterol and diabetes. Pt complains that he is not feeling like himself – no appetite, tired and maybe a touch of the flu. No other complaints.

- 10-1-13
  10:00 pm Pt Triaged
  11:00 pm MD assesses pt. orders therapeutic/additional dx modalities
  12:00 am Pt with new compliant of chest pain – additional therapeutic/dx modalities ordered.

- 10-2-13
  12:15 am MD re-evaluates and determines a need for medical necessity hospital services for this pt to beyond 2nd MN.
  12:35 am Formal order/admission provided. Order states: Admit to inpt. A list of orders for the pt is included.

- 10-3-13
  7:35 am Pt is discharged home

Is there 2 medically appropriate MNs outlined by the provider?
Can you 'see' the reason/plan for the 2 MN?
What are the key elements the UM and/or PA would be looking for as the 2nd MN approaches?
Is this a presumption or a benchmark case?
Is there risk with this case? Why or why not?

#2 Case Study (Table 1)
Looking for lost inpts.

84 year old female presented to the ED with abd pain , nausea , vomiting, and diarrhea with a temp of 101.5 and WBC 27.2.

- 2-12-15
  - 2:00 p.m. — Seen in the ED, medical treated
  - 3:21 pm — Order for observation for abd pain, n/v, temp 101.5
  - Active orders while in obs: IVF, IV bolus x1, obtain stool samples, 02, monitor temp, IV, antibiotics
- 2-22-15 — At the time of the order for the 2nd MN, the 02 sats were still low, continue 02. H&P was done at the time of the OBS placement.
- 2-23-15 — Discharged 11:13 am

- Is this patient eligible for inpt?
- Is there a medical reason to be in a bed?
- Is this a benchmark or presumption case?
- What are the risk factors if any?
- What would be some of the key elements the UM and/or PA would be assessing as the 2nd MN approaches?

#3 Case Study (Table #2)
Do we have a lost inpt below?

84 year old male presented to the MD office for increasing dyspnea and edema that did not respond to outpt. Diuretic therapy.

Treatment included echo, IV diuretics, abx, bronchodilators for wheezing, routine labs, CXR, IV lasix x1

Co-morbid conditions: TIA, stroke, CAD, HTN, COPD, Chemo 9-1-15.

10-12-15 Direct admit to OBS status.

No obs order found.

Care Mgt documented beginning of care/obs – 4:00 pm

Dx in order: CHF

Course of tx: Tele documentation x10 times in the note with no tele order. Strips mounted x3 times with RN signature and note. Increasing dyspnea and SOB that did not respond to outpt therapy.

10-13-15

Inpt order written at 1003 am.

At the time of inpt conversion – nursing wrote: 10-13 0930 – "Previous documentation from obs admission – refer to ambulatory assessment."

No physician documentation at time of conversion.

Standing Heart Failure Core Measure Orders are signed illegibly without a date, time, or any boxes checked to the order.

10-14-15 Discharged 1855

- Any risk factors?
- Is this an inpt? Why or why not?

#4 Case Study (Table 2) Hunting for a missed inpt!

78 year old man with a past and current medical history of chronic illnesses that are well controlled with medications.
Patient slips while shoveling and falls and sustains a closed wrist fracture.

- <u>11-9-13, Saturday</u>
  - 11:00 p.m — Pt presents to the ED following fall at home. Pt presents alone.
  - 11:30 pm — Pt arm facture confirmed by MD. Pain medication provided.

- <u>11-10-13, Sunday</u>
  - 3:30 am — Pt pain is well controlled, stable for discharge, but continues to required custodial care. No family or friends are available and hospital social services are unavailable until Monday am.
    Pt is held in the hospital pending home care plan, no IV access, pain well controlled with oral medication.

- <u>11-11-13, Mon</u>
  - 10:00 am — Discharge to home with family members. No other complaints.

Is this patient an inpt? What is their status?
Clarify the options for status change, if any?
What to do to reduce risk?

#5 Case Study (Table 3) How about this inpt?

73 year old male with an accidental environmental toxic exposure presents to the ED.

- <u>12-1-13</u>

9:00 am	Pt arrives by ambulance to the ED. Pt is awake and alert.
9:03 am	Poison control consulted which advises that pt requires telemetry monitoring; plan to intube if necessary. Small hospital facility, tele monitoring is only available in the ICU.
9:07 am	Therapeutic and Dx modalities have all been ordered and initiated. Pt airway intact.
10:00 am	MD requests transfer to ICU for Tele. Unclear to the physician is this pt will need medically necessary hospital level care/services for 2 or more MN. Determination will be dependent on clinical presentation and results of diagnostic and therapeutic modalities.

- <u>12-2-13</u>

10:30 am	Medical concerns/sequelae resolving; airway remained intact absent mechanical intervention.
12:00 noon	Physician writes orders to discharge.

- Was there an opportunity to make this an inpt? How about rare and unsual?
- ICU = Inpt? Discuss

#6 Case study (Table 3)

80 year old pt presents from home to the ED on a Sat for clinical presentation consistent with an acute exacerbation of chronic congestive heart failure. She is short of breath and hypoxic with ambulation. The physician determines that she will require hospital care for diuresis and monitoring, however it is unclear at presentation whether she will require 1 or 2 MN of hospital care.

- 12-7-15

  9:00 am — Pt begins receiving medical necessary services in the ED. She shows signs of fluid overload, requiring intravenous diuresis and supplemental 02 and continuous monitoring.

  11:00 am — IV diuretics are provided and an order for OBS is written with a plan to re-evaluate her within 24 hrs for the need for continued hospital care or discharge to home.

- 12-8-15

  9:00 am — She remains short of breath and hypoxic with ambulation, requiring additional IV diuresis and supplemental 02.

  5:00 p.m. — She continues to respond to diuretics but remains SOB and hypoxic with ambulation, requiring additional IV diuresis for another 12-14 hrs. Inpt order is written.

- 12-9-15

  10:00 am — Pt's acute CHF exacerbation is resolved and she is d/c home.

Is this an inpt? Why or why not?
What could have made the inpt order 'stronger?"

#7 Case study (Table 4)
Take a look at this one

Disabled 50 year old man presents to ED from home with history of cancer, now with probable metastases and various complaints, including nausea and vomiting, dehydration, and renal insufficiency.

- 1-1-14

  10:00 pm — Presents to the ED at which time the admitting provider evaluates and orders diagnostic and therapeutic modalities.

- 1-2-14

  4:00 p.m — Physician writes an inpt order. Pt is formally admitted with the expectation of medically necessary level of care/services for 2 or more midnights.

  9:00 am — Appropriate designee and the family discuss with the primary physician the desire for hospice care to begin for this pt immediately.

  3:00 p.m. — Patient is discharged with home hospice.

Is this a lost inpt?

Why or why not?

#8 Case study (Table 4)

80 year old male presents to ABC hospital in rural NC with an exacerbation of COPD on multiple medications. A new cardiac issue with SOB is identified. The ER provider requests the pt to be transferred to the higher level of care hospital. 50 miles away.

- 10-1-15 Saturday

  6:00 p.m. Pt is evaluated by ED provider. Care is initiated in the ED.

  7:00 p.m. A request for transfer to the higher level of care hospital/Jackson Hospital is requested by the Care Mgr/house supervisor (weekend)

  Receiving hospital will transfer in the am. Pt is kept in the hospital for stablization over night.

- 10-2-15 Sunday

  8:00 am Receiving hospital advises rural hospital there is no cardiologist available until Mon. It is determined is stable enough to remain at the initial hospital until Mon.

  Orders continue as from the initial ER visit. Numerous documentations entries regarding delay until Mom.

- 10-3-15 Mon

  11:00 am Pt is transferred to receiving hospital. Tests are ordered/completed prior to cardio consult.

  1:00 pm Cardiologist determines Cath procedure is necessary. Scheduled for 4:00 p.m.

  Routine recovery for safe discharge is completed at 01:00 am, 10-4-15.

Is this a lost inpt? Why or why not?

What put this account at risk?

#9 Case Study (Table 5)
A goodie!

72 year old F presented to ED via EMS c/o worsening productive cough, wheezing, and shortness of breath. Received IV solumedrol during transport to ED. EKG without changes, normal sinus rhythm, 02 sat 95-96% RA.

Per ED report, acute exacerbation of COPD, IV antibiotics, and RT treatments administered.
WBC count monitored.
ED 9-30-15 0253
No inpt order found.

H&P plan: Will monitor WBC count, start her on broad spectrum IV antibiotics and IV steroids, and continue RT treatments.
Progress notes: Less dyspnea, occasional cough, no wheezing. Change to po Prednisone, possible discharge 10-2-15.

Discharge summary: Seems to be improving…insisted on going home due to family issues.
Actual D/C : 10-1-15

Is this an inpt? Why or why not?
How could this have supported an unplanned short stay inpt?
What risk factors are present?

#10 Case study (Table 6) Did we lose this inpt?

78 year m presented to Ed complaining of bleeding gums… condition is chronic for past 35 years. Platelet count critically low at 5,000. 9-20-15 1100

Inpt order written by ED provider only/only bridge transitional orders. No authentication by attending. 9-20-15 1315

H&P plan: Patient is expected to need at least 2 MN for inpt care for the management of thrombocytopenia. Complicated by: Hypertension, irregular heart rate, hyperlipidemia, glaucoma. If not hospitalized, has a significant risk of bleeding to death.

Progress note: Thrombocytopenia resolved very nicely, patient is actually ready for discharge at this point. Will continue with oral prednisone. Follow up with Dr.__ Wean off steroids…other medical problems are stable.

Discharge summary: discussion with Dr ___ he was ready to be discharged .. Patient willing and ready to be discharged as well having no complaints. D/C 9-21-15

Is this inpt at risk? Why or why not?

What were the strengths in this short stay pt story?

(Can we clone this MD?) Happy face!

#11 Case Study (Table 6) Another fun inpt?

72 yr M presented to the physician's office 10 days post op from minimally invasive surgery for spinal stenosis. Pt c/o SOB, leg swelling and rapid HR, P 150. EKG showed new onset of rapid A fib.

He was direct admitted to ICU from the office for IV diltiazem. 1-19 1258

He converted in 4 hrs. His D-dimer was 2930 with a negative echo and deep vein ultrasound was negative.

LOS from COPE states 3 days but H&P states: Will observe overnight & probably D/C in AM."

No further notation or justification for inpt found in the chart.

D/c on 1-20-15.

Is this an inpt? Why or why not?

What is missing that could have supported inpt?

#12 Case Study (Table 7)
Do we have an inpt?

68 year old F presented to ED after having a syncopal episode at home. The pt was seen in the ED 3 days prior and was treated for UTI and sent home on antibiotics.

Because of the failed treatment and the syncopal episode, the ED physician and hospitalists felt she needed to stay overnight in OBS. She was treated with IV antibiotics and discharged the next day.

ED 1-22-14 0648

CPOE order set signed by PA/midlevel; not authenticated by MD directing care.

\ LOS: The PA wrote an admit order with LOS 2-3 days. The attending note prior to the 1st MN stated the LOS was 1 day.

Justification in the H&P by the PA: Failed outpt treatment for UTI

Discharged: 1-23-14 After care was included in the discharge note only

Is this an inpt? Why or why not?

What at risk issues are identified?

What internal processes should have occurred to prevent the at risk activity?

#13 Case Study (Table 7)

68 year old M brought to ED with increasing confusion and weakness. Labs showed BUN 32, eGFT 55, K+ 3.3, INR 3.2, Lactic acid 2.8 & troponin 0.098. CT brain had no acute findings.

ED: 5-12-15 1845

OBS: 5-12-15 1946

Treatment included: Telemetry, serial CEPs and EKGs, sliding scale insulin & holding Coumadin.

Co-morbid conditions: DM, OSA, CHF w/ED 30% payoxysmal a-fib, HTN, spinal stenosis.

Inpt order: 5-13-15 1503

At time of conversion: IV fluid was continued at 75cc/hr to complete 12 hrs. K+ had dropped to 2.9 & IV KCL was given. MRI brain was done, PT eval done and fentanyl patch was removed.

H&P was done when the pt was in obs.

D/C 5-14 1833

Is this an inpt? Why or why not?

What is missing that coul

#14 Case Study (Table 8)

74 year old M presented to the ED with non-functioning nephrostomy tube and hematuria from indwelling foley.
Recent dx of bladder CA with obstruction.

ED: 3-10-15 2150
Labs revealed K+ 5.9, Creatinine 2.3 & WBC 23,000

OBS: 3-11-15 0007
Treatment included IV bolus 1L, then 125 cc/h, IV rocephin, IV D50 & insulin and Kayexalate.
Scheduled transfer to another hospital for specialty care for next day.

Inpt order: 3-11-15 1426
Discharged to another hospital: 3-11-15 1704

Is this an inpt? Why or why not?
What are the risk factors?
Could this be a rare and unusual 1 day stay?

#15 Case Study (Table 8) How about this one?

68 year old M received in ED 6-26-15 1758

Came by ambulance for SOB. Also pt noticed he was having lower extremity edema and thought it might get worse.

Admitted to inpt 6-26-15 2022

H&P course: Admitted with a diagnosis of acute decompensated systotic congestive heart failure. He was given diauretics. He was found to be hyperkalemic. He had a very boardline tropinin evaluation. He had good diuresis.

H&P impression: (done 6-26 1123 pm)

Exacerbation of congestive heart failure with bilateral pleural effusion and volume overload, hyperkalemia, hx of Afib, well controlled. At this point in time, we are going to admit the patient for observation. He has already gotten 20 of lasix IV. Will give him another 20 of lasix for diuresis. We will hold all potassium, repeat his lab tonight about midnight to make sure that they are improving. Fluid restrict. No IV hydration and follow from here. Hopefully he will be able to discharge in the am.

D/C 6-27-15 1418

Was this an inpt? Why or why not

What risk factors are present in the documentation?

#16 Case Study (Table 9) Check out this one

84 year old M presented to the ED 2-13-15 at 1126 via EMS after a fall, a bleeding head wound requiring staples and hip, leg and knee pain. He has a history of COPD.

OBS: 2-13-15 1345

In the evening of 2-13, the pt began to drop his saturations to 88% and continued to drop and remain in the 80-92% range on 02 2L NC despite nebulizer treatments every 4 hrs.

On Sat, 2-14, the nurse documents in the plan of care, 'still having pain, pain meds and requires 02. will stay until Mon."

Discharged from OBS: 2-16 1331

Is this a missed inpt? Why or why not?

What documentation is missing to support inpt?

#17 Case Study (Table 9)

94 year old F presented to the ED 4-8-15 @1450. She was seen in the ER 4 days ago after a fall but the work up showed no significant injuries.

OBS: 4-8 @1830

She was back to her baseline on 4-10-15 but the nursing home couldn't take care of her due to lack of supplies for her treatment and due to the fact she needed a higher level of care than what they NH could provide. Referred to external PA on 4-8. No documentation of referral/discussion internally.

At the time of 2nd MN, she is improved but continued to receive NS for low sodium level, had crackles in her lungs and blood pressure elevations. Her 02 was in the 90s on 2 L NC.

At the day of discharge, her BNP was slightly elevated and she possibly aspirated.

D/C from obs on 4-13-15

Is this a missed inpt? Why or why not?

What are some of the 'confusing' factors?

What enhanced issues could have occurred?

#18 Case Study (Table 10) How about this one? Lost Inpt?

91 year old M present4ed to the ED 2-14 @0925 with progressive SOC due to end stage critical aortic stenosis .

OBS: 2-14 @1315.
At the time of the 2MN, he required insulin for high BS, required insulin coverage and received insulin.
His HGB/HCT was slowly dropping and he received a unit of blood on 2-16.

D/C from obs: 2-17 to rehab on hospice with 02.

ORDERS FROM PRE BUILT TEMPLATE:

Level of service	observation
Estimated LOS	2 days (discharge after midnight tomorrow)
Certification	I certify that Inpt services are medically necessary

Is this an inpt? Why or why not?
What are the conflicting factors?
What is missing?

#19 Case Study (Table 10)

- 66 year old F w/history of Hepatitis B and alcohol use presented to ED s/p fall at home. Husband reports that pt has unsteady gait (rubber legs) slurred speech, and frequent falls. Reports her to be increasingly lethargic, sleeping 1-17 hrs day. CT of the head w/o acute findings. Blood alcohol level 0.228 , liver enzymes elevated ALT 114, AST 228.

- 10-26 Inpt ordered at 0930. "Estimated to stay over 2 MN." /from a template in CPOE
- H&P : CIWA precautions and seizure precautions maintained. CIWA score 15.
- The patient is admitted with IV fluids, pulse oz, IV and oral Thiamine, EKG, NSR, HR 60. On telemetry, monitor overnight , reassess in the am.

- D/C 10-27 Mildly tremulous on presentation, received 1 dose Ativan, but then displayed no other symptoms of withdrawal. On the following day, she was ambulating indpently and discharged from home on her usual meds with information on local rehab services.

Is this a presumption inpt? Why or why not?

What is missing to support inpt?

#20 Case Study (Table 11) Looking for lost inpts

85 year old M severely retarded with psychiatric issues returned to the ER 3-26 @1031. Had been in the ER 6 hrs previously.

OBS: 3-26 1715

He was in CHF and renal failure with severe hypernatremia with a WB C of 17,000.

He was given Cardizem IV for atrial flutter with RVR but remained barely responsive to stimuli and was made DNR. All IVs and meds except comfort meds were stopped. The obs order is not signed.

He was to return to the group home per order 3-27 with hospice but d/c was delayed because group home could not take him until Mon.

He expired 3-29 at 0546.

At the 2nd MN, he required 02 @6L with low saturations, had coarse crackles in lungs.

Is this a missed inpt? Why or why not?

What key elements need addressed?

#21 Case Study (Table 11)

68 year old F presented to the ED c/o tight chest pain, radiating down left arm, also with SOB, diaphoresis and nausea. VSS, EKG concerning for unstable angina, troponin negative, nitroglycerin po, lovenox, cardiology consult. 11-11 0734

Inpt: 11-11 0848 With " Expected to cross 2 or more MN" checked.

H&P: Substernal chest pain/unstable angina. EKG with anterior wall ST depression, which resolved. Going through a lot of anxiety. Concern specific to acute coronary syndrome, questionable EKG changes, unstable angina.

Progress note: 11-11 There was initial concern for acute coronary syndrome because of apparent dynamic EKG changes noted by Cardiology. Cardiac catheterization revealed normal coronary arteries, ECHO with preserved LV function. She was felt to be inpt based on admitting dx of acute coronary syndrome/unstable angina. She improved earlier than anticipated and angiogram/evaluation was negative. She is thru being discharged home.

D/C 11-11 late in the evening

Was this a presumption inpt? Why or why not?

Documentation to support?

#22 Case Study (Table 12)
See a lost inpt?

72 yr old M to ED with 5 days of increasing cough, SOB, chills and fever. Can take 2-3 steps at a time and needs to rest. Pulse ox 86-87% RA.

Inpt order: 4-17 0143

Placed on 3 Liters of 02, lung bases diminished bilaterally. Duoneb treatments initiated. CXR to rule out pneumonia. Blood cultures, lovenox.

H&P: I anticipate the pt will be in the hospital 3 to 4 days ..will use steriods to control COPD. Acute exacerbation of COPD. We will get on IV antibiotics, IV steriods, mucolytics and pulmonary toilet in the form of Duoneb and albuterol.

Progress note 4-17: breathing better, afebrile, pulse ox 96-98%.

D/C 4-18 Got off 02 very quickly and responded to therapy extremely well. His lungs opened up nearly 100% with fairly preserved air exchange. He was discharged much quicker than anticipated. He was feeling well and wanted to go home.

Was this a presumption inpt? Why or why not?

What is at risk with this case?

#23 Case Study (Table 12)

68 year old F with recently dx'd lung CA, presented to radiology for ultrasound guided thoracenteses for malignant pleural effusion. During the procedure, she became hypotensive at 80/50 and felt dizzy. The cause was thought to be dehydration and she was placed in an OP bed for labs, tele, and IV hydration.

OBS: 10-5 1450

Her NA was low at 134, k+ was low at 2.8 & oral repletion was ordered along with observation and repeat labs in the am. It was decided to arrange transfer to another hospital for management of recurrent pleural effusion and initiation of oncology treatment.

Inpt admit: 10-6 2005

Transferred to another hospital the am of 10-7.

Is this an inpt? Why or why not?

How does the transfer impact the initial hospital?

The receiving hospital?

#24 Case Study (Table 13)
Looks good?

65 year old M brought to ED after being found at home unresponsive. Awake but weak and confused on arrival. Apparently had a fall at home and reported unable to get out of bed x 2-3 days. WBC 18,100

CRP 20, 02 sat 85% with wheezing and poor air movement, CK 2998. 6-19 1540

OBS: ER doctor placed in obs for syncope. 6-19 @1800

Inpt order: 6-20 1937 admitting documented sepsis with encephalopahty and rhabdomyolysis.

Treatment with IV meds, tele, 02 and nebs. Still confused, wheezy and requiring 02, WBC 15,200 and a new onset of Afib.

Expired 6-22 following a code.

Is this an 2 MN benchmark case? Why or why not?

What risk factors are prese

#25 Case Study (Table 13)

81 yr old M presented to the ED after a fall in the assisted living facility. He has worsening severe dementia. Pt was held due to not cooperating. 9-1-15 1430

OBS: 9-1 1851 While in obs, neuro checks, monitor pain, monitor and treat skin tears, straight cath, send UA specimen, MRSA swab.

9-2 Pt has begun to slur his speech. UA culture is pending for a positive UA and pt is unable to walk. CT of the head is ordered. Rib pain, right orbital contusion.

D/C from obs: 9-3 1031

Is this a missed inpt? Why or why not?

What documentation made it difficult?

#26 Case study (Table 14)
This is a good one!

72 year old F presented to the ED 4 days ago for a T7 compression fracture and presented this date for intractable pain and constipation. 10-25 1409

OBS: placed for intractable pain and constipation. Treated with IV meds, IVF, nausea medication. 10-25 1841

Inpt order: 10-27 1543 for continued IV pain and nausea medication.

Then placed back into obs: 10-30 1201 with no notation other than the order. She underwent a kyphoplasty 11-2 and was discharge 11-3 as obs.

No documentation for CC 44 if accurate.

Is this an inpt? Why or why not?

What confusing factors were present?

Sort this one out and advise on multiple status changes, if appropriate.

#27 Case Study (Table 14)

70 year old M presented to the ED with rash/itching all over, constipation, SOB and urinary retention.

9-23 1907

OBS: 9-24 0310

Monitor U OP/foley, bladder scan, straight cath, monitor BP, itching, treat with cream, contact isolation, sliding scale insulin.

At the 2nd MN, he was still being monitored for HTN with new meds, BS monitored, foley remained, HR monitored on tele.

D/C in obs: 9-29 1902

Is this a missed inpt? Why or why not?

What could help the documentation?

#28 Case Study (Table 15)
Check this one

67 year old homeless M presented to the ED with chest pain, diaphoresis, leg pain and SOB.
States he cannot care himself and has no where to go. 9-2 2233

OBS: 9-3 0655
Monitor pain, pain patches, assist in trach care, monitor anxiety, and respiratory status. TF, TF site care.

At the 2nd MN, pt had multiple continued care complaints including SOB. He refused some medications.

D/C 'home' obs: 9-9 1406

Is this a missed inpt? Why or why not?
What complicating factors are present?

#29 Case Study (Table 15)

83 year old M presented to the ED 1027 @1647 with dyspnea on exertion & episodes of unstable angina, BP 160-180s over 90-130s. EKG showed age-inderminate LKBBB.

OBS: 10-27 -15 1741

HTN was treated by po Metoprolol, with tele, serial CEPs and EKGs. Cardiology was consulted & scheduled a heart cath for 10-28 resulting in percutaneous intervention to rt coronary artery, lt circumflex artery & first marginal artery w/stents.

Inpt: 10-28 with routine post stent care.

At time of conversion: Inpt status, as based on my clinical experience and complex medical judgment, I expect the pt will require hospitalization that crosses 2 MN before discharge, considering his currently identified dx findings and medical needs that cannot be safely provided in an outpt setting/template. (In hunting, found unstable angina, LBBB on EKG with interventions.)

Is this an inpt? Why or why not?

What are the risk factors identified?

How could this be improved?

#30 Case Study (Table 16)
Do we have a lost inpt below?

84 year old male presented to the MD office for increasing dyspnea and edema that did not respond to outpt. Diuretic therapy.

Treatment included echo, IV diuretics, abx, bronchodilators for wheezing, routine labs, CXR, IV lasix x1

Co-morbid conditions: TIA, stroke, CAD, HTN, COPD, Chemo 9-1-15.

10-12-15 Direct admit to OBS status.

No obs order found.

Care Mgt documented beginning of care/obs – 4:00 pm

Dx in order: CHF

Course of tx: Tele documentation x10 times in the note with no tele order. Strips mounted x3 times with RN signature and note. Increasing dyspnea and SOB that did not respond to outpt therapy.

10-13-15

Inpt order written at 1003 am.

At the time of inpt conversion – nursing wrote: 10-13 0930 – "Previous documentation from obs admission – refer to ambulatory assessment."

No physician documentation at time of conversion.

Standing Heart Failure Core Measure Orders are signed illegibly without a date, time, or any boxes checked to the order.

10-14-15 Discharged 1855

- Any risk factors?
- Is this an inpt? Why or why not?

#31 Case study (Table 16)

80 year old pt presents from home to the ED on a Sat for clinical presentation consistent with an acute exacerbation of chronic congestive heart failure. She is short of breath and hypoxic with ambulation. The physician determines that she will require hospital care for diuresis and monitoring, however it is unclear at presentation whether she will require 1 or 2 MN of hospital care.

- 12-7-15

  9:00 am — Pt begins receiving medical necessary services in the ED. She shows signs of fluid overload, requiring intravenous diuresis and supplemental 02 and continuous monitoring.

  11:00 am — IV diuretics are provided and an order for OBS is written with a plan to re-evaluate her within 24 hrs for the need for continued hospital care or discharge to home.

- 12-8-15

  9:00 am — She remains short of breath and hypoxic with ambulation, requiring additional IV diuresis and supplemental 02.

  5:00 p.m. — She continues to respond to diuretics but remains SOB and hypoxic with ambulation, requiring additional IV diuresis for another 12-14 hrs. Inpt order is written.

- 12-9-15

  10:00 am — Pt's acute CHF exacerbation is resolved and she is d/c home.

Is this an inpt? Why or why not?
What could have made the inpt order 'stronger?"

#32 Case Study (Table 17)
See a lost inpt?

72 yr old M to ED with 5 days of increasing cough, SOB, chills and fever. Can take 2-3 steps at a time and needs to rest. Pulse ox 86-87% RA.

Inpt order: 4-17 0143

Placed on 3 Liters of 02, lung bases diminished bilaterally. Duoneb treatments initiated. CXR to rule out pneumonia. Blood cultures, lovenox.

H&P: I anticipate the pt will be in the hospital 3 to 4 days ..will use steriods to control COPD. Acute exacerbation of COPD. We will get on IV antibiotics, IV steriods, mucolytics and pulmonary toilet in the form of Duoneb and albuterol.

Progress note 4-17: breathing better, afebrile, pulse ox 96-98%.

D/C 4-18 Got off 02 very quickly and responded to therapy extremely well. His lungs opened up nearly 100% with fairly preserved air exchange. He was discharged much quicker than anticipated. He was feeling well and wanted to go home.

Was this a presumption inpt? Why or why not?

What is at risk with this case?

#33 Case Study (Table 17)

- 66 year old F w/history of Hepatitis B and alcohol use presented to ED s/p fall at home. Husband reports that pt has unsteady gait (rubber legs) slurred speech, and frequent falls. Reports her to be increasingly lethargic, sleeping 1-17 hrs day. CT of the head w/o acute findings. Blood alcohol level 0.228 , liver enzymes elevated ALT 114, AST 228.

- 10-26 Inpt ordered at 0930. "Estimated to stay over 2 MN." /from a template in CPOE
- H&P : CIWA precautions and seizure precautions maintained. CIWA score 15.
- The patient is admitted with IV fluids, pulse oz, IV and oral Thiamine, EKG, NSR, HR 60. On telemetry, monitor overnight , reassess in the am.

- D/C 10-27 Mildly tremulous on presentation, received 1 dose Ativan, but then displayed no other symptoms of withdrawal. On the following day, she was ambulating indpently and discharged from home on her usual meds with information on local rehab services.

Is this a presumption inpt? Why or why not?

What is missing to support inpt?