Medical Chronology/Summary

Confidential and privileged information

Usage guidelines/Instructions

Verbatim summary: All the medical details have been included "word by word' or "as it is" from the provided medical records to avoid alteration of the meaning and to maintain the validity of the medical records. The sentence available in the medical record will be taken as it is without any changes to the tense.

Case synopsis/Flow of events: For ease of reference and to know the glimpse of the case, we have provided a brief summary including the significant case details.

Injury report: Injury report outlining the significant medical events/injuries is provided which will give a general picture of the case.

Comments: We have included comments for any noteworthy communications, contradictory information, discrepancies, misinterpretation, missing records, clarifications, etc for your notification and understanding. The comments will appear in red italics as follows: "***Comments***".

Indecipherable notes/date: Illegible and missing dates are presented as "00/00/0000" (mm/dd/yyyy format). Illegible handwritten notes are left as a blank space "_____" with a note as ***"Illegible Notes"*** in heading reference.

Patient's History: Pre-existing history of the patient has been included in the history section.

Snapshot inclusion: If the provider name is not decipherable, then the snapshot of the signature is included. Snapshots of significant examinations and pictorial representation have been included for reference.

De-Duplication: Duplicate records and repetitive details have been excluded.

General Instructions:

- *The medical summary focuses on **Case Name** hospitalization for shortness of breath on 12/27/YYYY followed by left heart catheterization on 01/02/YYYY for management of new onset systolic congestive heart failure, and subsequent development of retroperitoneal bleed complicating left heart catheterization, and its management till death on 01/03/YYYY.*

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Flow of events

AB Hospital
12/27/YYYY-01/03/YYYY

Presented to ER via EMS for shortness of breath – Assessed with CHF, hypertensive emergency, hypoxia, COPD exacerbation, pulmonary edema, and lactic acidosis – Admitted – Started on antibiotics – ID and Cardiology consulted – Medical management provided – Placed on supplemental oxygen – Transthoracic echocardiogram obtained on 12/29/YYYY showed left ventricular wall thickness in a pattern of mild LVH, mild diffuse hypokinesis, decreased left ventricular diastolic compliance and/or increased left atrial pressure, moderately calcified mitral valve leaflet with mild mitral regurgitation – Assessed with worsening LVEF and planned for LCH for management of pulmonary vascular congestion – On 01/02/YYYY, underwent left heart catheterization, selective coronary angiography, and left ventriculography under moderate conscious sedation for management of new onset systolic congestive heart failure in a patient with known coronary artery disease – At 1139 hours, noted with softball sized hematoma of right abdomen, desaturated to 77 off oxygen - Dr. XXXX ordered for patient to be brought to cath lab - Underwent aortoiliac angiography with selective right iliac artery angiography for evaluation of low blood pressure and possible hematoma concern for retroperitoneal hematoma that showed no evidence of contrast extravasation in the left external iliac or left common femoral artery –

On 01/03/YYYY, complained of severe pain in the abdomen – CT of abdomen ordered to evaluate for retroperitoneal bleed that showed large mixed density right retroperitoneal hematoma extending to the right pelvic sidewall/inguinal canal measuring up to 14.7 cm and several small foci of contrast blush within the collection noted on arterial phase imaging compatible with active hemorrhage – Hemoglobin level dropped – Assessed with suspected retroperitoneal bleed complicating left heart catheterization – Repeat hemoglobin and hematocrit q2hrs was recommended – IR consult and PRBC transfusion recommended – On exam, noted to have a very large protrusion on her right abdomen, which was clearly the hematoma - CT showed severe stenosis of the left common iliac artery, and the right groin was compromised by the large hematoma - Evaluation of the left wrist showed extensive ecchymosis - Triple lumen central venous catheter placement was planned in the right neck for infusion of pressors and blood products - The nurses and techs spent the next 15 minutes or so searching for supplies only to find that many of the necessary equipment - In the time they spent looking for supplies, the patient stopped breathing and was not arousable - A code was called and CPR was initiated - After roughly 45 minutes of running the code, the patient was pronounced dead at 2109 hours

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Patient History

Past Medical History: Arthritis, Atrial fibrillation, Brain aneurysm, CAD - Coronary artery disease, Carotid artery stenosis, Cataract, COPD, moderate, GERD - Gastro-esophageal reflux disease, Glaucoma, Hepatitis C, Hiatal hernia, IBS (irritable bowel syndrome), Myocardial infarction, Sleep apnea ***(PDF-Ref:** 22)*

Surgical History: Carotid artery stent, Cataract surgery, Hysterectomy, Pacemaker, Sinus surgery twice, Stent placement, TNF ***(PDF-Ref:** 22)*

Family History: Mother: Chronic obstructive pulmonary disease ***(PDF Ref:** 23)*

Social History: Denies alcohol use, never used electronic cigarette/vaping, denies substance abuse, former smoker ***(PDF-Ref:** 22-23)*

Allergy: No known allergies ***(PDF-Ref:** 22)*

Detailed Summary

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
12/27/YYYY	Hospital/ Provider Name	**EMS/Ambulance Report:** **Incident report:** **Incident summary:** **Type of service requested:** 911 response **Nature code:** Difficulty breathing **Incident/patient disposition:** ALS (Transfer Care to Phx Ambo) **Destination name:** (SJE) St Joes Hospital ER Adult **Incident information:** **Level of service:** ALS **Cardiac arrest:** No **Suspected stroke or TIA?** No **Incident location:** **Incident location type:** Single-family non-institutional (private) house **City:** PHX **Incident state:** AZ **County:** Maricopa **Call times:** **Call received:** At 0958 hours **Dispatched:** At 1009 hours **En route:** At 1010 hours **On scene:** At 1020 hours **At patient:** At 1025 hours **Rescue leave:** At 1040 hours **Unit clear:** At 1042 hours **At hospital:** At 1052 hours **EMS transport method:** Ground-Ambulance **Reason for choosing destination:** Closest facility **General history:** **History obtained:** Bystander/other; Family **Medical history:** CHF, COPD, CVA/stroke **At 1003 hours:** **ECG rhythm:** Paced rhythm **Vitals:** BP: 182/78, HR: 88, O2 sat: 94, RR: 20, ETCO2: 43 **GCS:** 15 (Motor: 6; verbal: 5; eye: 4)	493-499

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		At 1019 hours **ECG rhythm:** Sinus rhythm **Vitals:** BP: 180/90, HR: 88, O2 sat: 94, ETCO2: 42 **At 1047 hours:** **ECG rhythm:** Sinus rhythm **Vitals:** BP: 180/93, HR: 75, O2 sat: 99, RR: 20, ETCO2: UTO **Narrative:** **On Scene Narrative (Author):** On arrival, engine 14 found patient sitting in home upright with complaint of difficulty breathing. Patient states that she woke up with an aching chest pain that radiates to her back. Patient states that associated is difficulty breathing. Patient extensive medical history. Patient alert and oriented person, place, time, event. Patient assessed vitals times two all within normal range with the exception of being hypertensive. Patient has a history of stroke which right side has pain. Patient transported via rescue 903 to Banner University for further evaluation. **Transport Narrative:** Patient monitored throughout transport. 12 lead performed en route, hospital staff notified upon arrival to hospital that pt may be a STEMI, paramedic from fire dept requested a physician from charge nurse for possible STEMI. E14 stated on scene they administer 324 of ASA which was relayed to staff of accepting facility. Pt transferred to St Joseph's hospital, the facility the patient specifically requested.	
		ABC Hospital and Medical Center ***12/27/YYYY-01/03/YYYY***	
12/27/YYYY	Hospital/ Provider Name	**ER Triage Record:** **Chief Complaint ED:** Chest pain **Arrival Time:** 12/27/YYYY at 1056 hours **Reason for visit:** Respiratory dysfunction **Triage Assessment:** BIBA. Per EMS patient had acute onset of chest pain with breathing difficulty starting around 0700 today. **Mode of Arrival:** Ambulance **Vitals:** NIBP: 228/107, HR: 91, RR: 32, SpO2: 87%, oxygen method: Room air, pain intensity: 0 SIRS actual or suspected infection: Yes Height: 165.1 cm Weight: 120 lbs BSA: 1.58 BMI: 19.966 Ideal body weight: 57 kg Adjusted body weight: 0 kg	500-502
12/27/YYYY	Hospital/ Provider Name	**@ 1103 hours: ER Physician Record:** **Admit time:** At 1056 hours **Provider contact time:** At 1102 hours **Mode of arrival:** Ambulance	21-27

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Chief complaint: Shortness of breath **History of present illness:** Patient is a 82 year old female with a history of COPD, sleep apnea, A-fib, CAD s/p percutaneous coronary angioplasty with stents, prior MI x 3, HTN, CVA, and glaucoma who presents to the ED today brought in by ambulance for evaluation of lower right-sided "achy" chest pain and shortness of breath since she woke up this morning around 0700 am. Per EMS, patient was given 324 Aspirin in route. She states she uses 2L of oxygen at home at night. Patient states she takes her blood pressure every morning prior to taking her medications and she noticed it was lower than usual this morning so she waited to take her daily pills and still has not taken them. She denies other symptoms today including fever, chills, cough, congestion, sore throat, nausea, vomiting, diarrhea, constipation, dysuria, hematuria, headache, dizziness, or lightheadedness. Patient states she follows with Dr. Nag **Review of systems:** Negative except as documented in HPI. **Problem list:** **Ongoing:** Abdominal pain, Acute on chronic respiratory failure, Acute respiratory failure with hypoxia, Adrenal insufficiency, Atrial fibrillation, Atrial fibrillation with RVR, Back pain, Brain aneurysm, CAD S/P percutaneous coronary angioplasty, Carotid artery disorder, Chest pain, rule out acute myocardial infarction, Chronic a-fib, Chronic respiratory failure, Constipation, COPD exacerbation, COPD without exacerbation, COPD, frequent exacerbations, CVA, old, hemiparesis, Diverticular disease, Esophagitis, Gastric reflux, Glaucoma, Hiatal hernia, High risk for readmission, History of CVA with residual deficit, History of sick sinus syndrome, Hypertensive urgency, Knee injury, Lung nodule, Osteoporosis, Pacemaker, Protein calorie malnutrition, Rib pain on left side, S/P angioplasty with stent, S/P placement of cardiac pacemaker, Sick sinus syndrome, Sleep apnea, Stented coronary artery, Stercoral colitis, Tachy-brady syndrome, Thyroid nodule **Home medications:** Acetaminophen 325 mg oral tablet, 650 mg= 2 Tab, PO, q6hr Albuterol 0.083% NEB, 2.5 mg= 3 mL, INH, every 6 hours, PRN Albuterol 90 mcg/inh inhalation aerosol, 2 Puff, INH, every 4 hours, PRN Cholecalciferol 50 mcg (2,000 unit) oral capsule, 50 mcg= 1 Cap, PO, qDay Clonidine 0.1 mg oral tablet, 0.1 mg= 1 Tab, PO, BID, PRN, PRN for SBP >160 Combivent Respimat 20 mcg-100 mcg/inh inhalation aerosol, 1 Puff, INH, QID Coreg 12.5 mg oral tablet, 25 mg= 2 Tab, PO, BID Digoxin 125 mcg (0.125 mg) oral tablet, 125 mcg= 1 Tab, PO, qDay Dulcolax 10 mg rectal suppository, 10 mg= 1 Supp, PR, qDay, PRN, Please hold for diarrhea Eliquis 2.5 mg oral tablet, 2.5 mg= 1 Tab, PO, BID Fluticasone CFC free 110 mcg/inh inhalation aerosol with adapter, 2 Puff, INH,	

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		BID Lisinopril 40 mg oral tablet, 40 mg= 1 Tab, PO, qDay MiraLax oral powder for reconstitution, 17 gm, PO, BID, Hold for loose stools, dissolve in water before taking Outpatient physical therapy and occupational therapy, See Instructions, Prescription for outpatient Physical therapy and occupational therapy Plavix 75 mg oral tablet, 75 mg= 1 Tab, PO, qDay Protonix 40 mg oral delayed release tablet, 40 mg= 1 Tab, PO, qDay **Physical examination:** **@ 1100 hours: Vitals:** BP: 228/107, HR: 91, RR: 32, SpO2: 87%, oxygen amount: 4, oxygen method: Room air Pulse ox hypoxic on room air as interpreted by myself **General:** Alert, no acute distress. **Skin:** Warm, dry, pink, intact, no rash, normal for ethnicity. **Head:** Normocephalic, atraumatic. **Neck:** Supple, trachea midline, no tenderness, no JVD. **Eye:** Pupils are equal, round and reactive to light, extraocular movements are intact, normal conjunctiva. **Ears, nose, mouth and throat:** Tympanic membranes clear, oral mucosa moist, no pharyngeal erythema or exudate. External auditory canals normal bilaterally, oropharynx normal. **Cardiovascular:** Tachycardiac, no murmur, normal peripheral perfusion, no edema. Non-displaced point of maximal impulse. Normal S1, S2. No gallops. **Respiratory:** Tachypneic, breath sounds are diminished in bilateral bases, symmetrical chest wall expansion. **Chest wall:** No tenderness, no deformity. **Back:** Non-tender, Normal range of motion, normal alignment, no step-offs. **Musculoskeletal:** Normal range of motion, normal strength, no tenderness, no swelling, no deformity. **Gastrointestinal:** Soft, non-tender, non-distended, normal bowel sounds. **Neurological:** Alert and oriented to person, place, time, and situation. No focal neurological deficit observed, cranial nerves II-XII intact, normal sensory observed, normal speech observed. Normal reflexes, normal motor. 5/5 to upper and lower extremities. **Psychiatric:** Cooperative, appropriate mood & affect. **Most recent vitals:** Temperature: 36.6C, HR: 75, RR: 22, BP: 190/116, SpO2: 97%, oxygen method: Nasal cannula, weight: 54.422 kg (120 lbs) **Orders for this visit:** IV Saline Lock, once. XR Chest 1 View Portable Electrocardiogram Urinalysis Isolation Albuterol-ipratropium: 3 mL, NEB - inhalation, x1. Sodium chloride: 10 mL, IV Push, q12hr.	

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		Sodium chloride: 10 mL, IV Push, Per Parameter, PRN: Other Sodium chloride: 10 mL, IV Push. Aerosol Treatment Magnesium sulfate: 2 gm, 50 mL, 150 mL/hr, IV, x1, PRN: Other (see Comments). Methylprednisolone: 125 mg, IV Push, once. ED Initial Screening Methylprednisolone: ADM, x1. Albuterol-ipratropium: ADM, x1. RT Evaluate and Treat Protocol Albuterol: ADM, x1. Albuterol: ADM, x1. Culture Blood Magnesium (Mg) Level PT BNP (B-Type Natriuretic Peptide) Troponin-I Procalcitonin Lactic Acid w/Reflex Comprehensive Metabolic Panel CBC with differential Creatine Kinase Phosphorus (PO4) Level Culture Blood Aerosol Treatment Albuterol: 10 mg, NEB - inhalation, x1. Clonidine: 0.2 mg, PO, x1. Clonidine: ADM, x1. COVID19 Symptomatic/Influ AB/RSV Pnl PCR Intent to Admit (ED only): Level of Care: Medical Surgical with Telemetry, COPD exacerbation, Hypoxia, Congestive heart failure, Pulmonary edema, Hypertensive emergency, Lactic acidosis, Admitting MD: XXXX, M.D. Lactic Acid Sodium chloride: 10 mL, IV Push. Sodium chloride: 10 mL, IV Push. **Procedure:** **Critical care notes:** **Total time:** 35 minutes spent engaged in work directly related to patient care and/ or available for direct patient care. **Critical condition(s) addressed for impending deterioration include:** Airway, respiratory, cardiovascular. **Associated risk factors:** Hypotension, shock, hypoxia. **Management:** Bedside assessment, supervision of care, Interpretation (chest X-ray, blood pressure, cardiac output measures), Interventions hemodynamic management. **Performed by:** Self.	

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		Notes: 35 minutes of critical care, excluding time spent in procedures billed separately and time spent teaching, was provided for this patient in order to treat vital organ failure and prevent further life-threatening deterioration of the patient's condition. The duration of critical care services are inclusive of time I spent evaluating, providing care and managing the critically ill patient during which I was unable to attend to other patients; furthermore, withdrawal of, or failure to initiate these interventions on an urgent basis would likely result in sudden, clinically significant or life threatening deterioration in the patient's condition *Labs and images reviewed.* **Reexamination/Reevaluation:** **At 1212 hours:** Patient reevaluated. She is now hypertensive and refusing IV medications for blood pressure control at this time. She states she is afraid of taking anything IV because one time she had IV medications and her blood pressure dropped too low. Will attempt oral medications. **At 1300 hours:** Patient reevaluated. Patient is resting comfortably. Discussed results of ED workup with the patient, who verbalized understanding. Discussed the indication for admission to the hospital for further management. The patient is agreeable. All questions and concerns were addressed. **Medical Decision Making** **History was obtained directly from:** The patient, EMS and medical records **Records reviewed include:** Prior admissions Imaging studies and labs were ordered and interpreted as above. All labs and EKG's were independently reviewed by me and all imaging was either read or reviewed by me. If read by the radiologist, I agree with the radiology report. **Further discussions with health care professionals not documented in the consult section of the note include:** None **Social determinants of health affecting care include:** None **The patient's chronic conditions are:** Stable **Comorbid conditions impacting evaluation or treatment, or that add to the complexity of management:** None **There is evidence of drug toxicity requiring further treatment and no illness with high morbidity without treatment:** No **The patient is on outpatient prescriptions affecting other chronic conditions.** No **The patient has an immediate need for hospitalization based on their examination and testing today as well as their response to treatment:** Yes **There is an indication for further emergent testing:** No Shared decision making was utilized **The patient responded well to supportive treatments in the ED:** Yes **Dispo:** Admit **Consults** **At 1218 hours:** Paged ZION.	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		At 1247 hours: Return call from Dr. Owusu, with ZION. Discussed patient's case at length. They are agreeable for admission under their care. **Final diagnosis:** **Diagnosis this visit:** Congestive heart failure Hypertensive emergency Hypoxia COPD exacerbation Pulmonary edema Lactic acidosis **Disposition:** **Intent to Admit (ED only):** At 1305 hours, Level of Care: Medical Surgical with Telemetry, COPD exacerbation, Hypoxia, Congestive heart failure, Pulmonary edema, Hypertensive emergency, Lactic acidosis, XXXX MD: XXXX, M.D. **Condition:** Stable **Comments:** Patient counseled regarding diagnosis, diagnostic results, and the treatment plan. Patient indicated understanding of instructions. **Disclaimer:** All medical record entries made by the scribe were at my direction. I have reviewed the chart and agree that the record accurately reflects my personal performance of the history, physical exam, medical decision making, and the emergency department course for this patient. I have also personally directed and agree with the discharge information and disposition, if patient was discharged at this point in their emergency department course.	
12/27/YYYY	Hospital/ Provider Name	**@ 1108 hours: EKG:** Sinus rhythm with occasional ectopic premature complexes Borderline right axis deviation Possible anterior myocardial infarction , of indeterminate age ST deviation and Moderate T-wave abnormality, consider inferior ischemia	39-40, 88
12/27/YYYY	Hospital/ Provider Name	**@ 1136 hours: Labs:** **High:** Hemoglobin:14.5, PT: 15.9, INR: 1.3, glucose: 154, BUN/creatinine ratio: 26, B-Natriuretic peptide: 691.6 **Low:** EGFR: 71 **Normal:** WBC: 9.5, RBC: 4.78, hematocrit: 44.3	764-766
12/27/YYYY	Hospital/ Provider Name	**@ 1145 hours: X-Ray of Chest:** **Ordering provider:** Kevin O'Mara, M.D. **Comparison:** X-ray of chest dated 11/12/YYYY, X-ray of chest dated 10/27/YYYY, X-ray of chest dated 11/07/YYYY, X-ray of chest dated 07/28/YYYY **Provided indications:** Shortness of Breath **Findings/impression:**	762-763

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		Patchy opacity at the left lung base, which may represent pneumonia or focal pulmonary edema. Pulmonary vascular congestion. Right upper lobe calcified granuloma. No significant pleural effusion or pneumothorax. Pacemaker. Normal sized heart. Aortic calcifications. Degenerative changes of the shoulders.	
12/27/YYYY	Hospital/ Provider Name	**@ 1642 hours: History and Physical:** **Chief Complaint:** Shortness of breaths **History of present illness:** Patient is a 82 year old female with a history of COPD, sleep apnea, A-fib, CAD s/p percutaneous coronary angioplasty with stents, prior MI x 3, HTN, CVA, and glaucoma who presents to the ED today brought in by ambulance for evaluation of lower right-sided "achy" chest pain and shortness of breath since she woke up this morning around 0700 AM. Per EMS, patient was given 324 Aspirin in route. She states she uses 2L of oxygen at home at night but she has been needing more supplemental oxygen lately. She has had no fever. She admits to increased cough and sputum production. **Review of Systems:** Ten system review negative except as noted above. **Objective:** **Vitals & Measurements:** Temperature: 36.6 °C (Oral) HR: 67 RR: 30 BP: 141/65 SpO2: 98% Oxygen Method: Nasal cannula WT: 54.422 kg WT: 120 lbs **Physical examination:** **General:** Patient is awake and alert. Patient does not appear to be in any distress and is cooperative. Patient is oriented by 3. **CVS:** Heart sounds 1 and 2 are present. Regular beats **Chest:** Reduced air entry bilaterally. Crepitations to the bilateral lung bases. *Otherwise unremarkable.* *Labs and images reviewed.* **Assessment/plan:** • COPD with exacerbation • Acute on chronic congestive heart failure • Hypertensive emergency • Hypoxemia acute on chronic. • Lactic acidosis • Pulmonary edema • Atrial fibrillation • Community-acquired pneumonia **Plan:** • Admit patient to telemetry bed. • Zithromax and Rocephin	1-5

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• IV Lasix • Restart Eliquis • Replace electrolytes • IV Solu-Medrol **Orders:** Tylenol oral tablet, 650 mg, PO, Tab, q4hr Priority: Routine PRN Temperature, For temperature equal or greater than 38 C Tylenol oral tablet, 650 mg, PO, Tab, q4hr Priority: Routine PRN Pain Mild (1-3) Duoneb, 3 mL, NEB - inhalation, HHN, q2hr Routine PRN Secretions Eliquis, 2.5 mg, PO, Tab, BID Routine Zithromax, 500 mg, IV, qDay Routine, Indication: Pneumonia, Infuse over: 1 hr Dulcolax, 10 mg, PR, Supp, qDay Routine PRN Constipation Coreg, 25 mg, PO, Tab, BID Routine Ceftriaxone (Rocephin) for IV Push, 1,000 mg, IV Push, INJ, q24hr Routine, Indication: Pneumonia Cholecalciferol, 50 mcg, PO, Cap, qDay Routine Clonidine, 0.1 mg, PO, Tab, BID Routine PRN Blood Pressure - see order comments Plavix, 75 mg, PO, Tab, qDay Routine Digoxin, 125 mcg, PO, Tab, qDay Routine Lasix, 20 mg, IV Push, INJ, BID Routine Lisinopril, 40 mg, PO, Tab, qDay Routine Magnesium oxide, 400 mg, PO, Tab, Per Parameter Routine PRN Hypomagnesemia Magnesium sulfate 2gm/50 mL SW, 2 gm, IV, Bag, Per Parameter Routine PRN Hypomagnesemia, Infuse over: 2 hr Magnesium sulfate 4gm/100 mL SW, 4 gm, IV, Bag, Per Parameter Routine PRN Hypomagnesemia, Infuse over: 4 hr Solu-Medrol (Methylprednisolone Na succ), 40 mg, IV Push, INJ, q8hr Routine Zofran INJ, 4 mg, IV Push, INJ, q4hr Priority: Routine PRN Nausea / Vomiting 1st Choice OxyIR, 5 mg, PO, Tab, IR, q6hr Priority: Routine PRN Pain Moderate to Severe (4-10) Protonix, 40 mg, PO, Tab, EC, qDay Routine, GERD MiraLax, 17 gm, PO, Pwd, BID Routine KCL 10 mEq/100 mL IVPB, 10 mEq, IV, Bag, Per Parameter Routine PRN Hypokalemia, Per KCl Replacement to 4 Powerplan, Infuse over: 60 min Potassium chloride (Klor-Con) ER Tab, 20 mEq, PO, Tab, ER, Per Parameter Routine PRN Hypokalemia, Per KCl Replacement to 4 Powerplan Potassium chloride (Klor-Con) ER Tab, 40 mEq, PO, Tab, ER, Per Parameter Routine PRN Hypokalemia, Per KCl Replacement to 4 Powerplan Fluticasone CFC free 110 mcg/inh inhalation aerosol with adapter, fluticasone CFC free 110 mcg/inh inhalation aerosol with adapter, 2 Puff, Aerosol, INH, BID, Routine Activity Advance as Tolerated Activity as Tolerated Cardiac Diet	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		CBC w/Differential (man diff if indicated) CMP (BMP + ALB, Tot Prot, Bili, CA, Alk Phos, ALT, AST) Code Status Full Magnesium (Mg) Level Magnesium Replacement Monitoring Notify MD if Patient Placement Potassium Level Potassium Replacement Monitoring to 4.0 Vital Signs	
12/27/YYYY	Hospital/ Provider Name	**@ 1758 hours: Urinalysis:** *Unremarkable.*	768
12/28/YYYY	Hospital/ Provider Name	**@ 0126 hours: Labs:** **High:** Absolute neutrophils: 8.6, glucose: 156, BUN: 26, BUN/creatinine ratio: 33 **Low:** EGFR: 75, total protein: 6.1, albumin: 3.4 **Normal:** WBC: 9.5, RBC: 4.03, hemoglobin: 12.3, hematocrit: 36.9	764, 766
12/28/YYYY	Hospital/ Provider Name	**@ 1407 hours: Cardiology Consultation Report:** *XXXX, AGACNP* **Referring Physician:** IM **Reason for Consultation:** CHF **Chief Complaint:** Dyspnea **History of Present Illness** 82 year-old female with PAF, PPM, CAD s/p inferior wall STEMI in 2007, status post Taxus DES to the RCA, recurrent MI in 2021 requiring stenting of the LAD hypertension, COPD, recurrent carotid artery disease status post left CEA with subsequent left carotid artery stenting and arthritis seen in ER for c/o CP & dyspnea. Dx with PNA yesterday, started IV ABX. Significant hypotension this AM after medications given, now with intermittent L sided CP. Given Liter bolus, pending repeat trop. Currently CP free. Family @ bedside. **Review of systems:** *All systems reviewed and are negative.* **Objective:** **Vitals:** Temperature: 36.4C, HR: 68, RR: 24, BP: 135/73, SpO2: 98%, oxygen method: Nasal cannula, weight: 49.206 kg (108.5 lbs) **Physical examination:** **General:** No acute distress, alert and oriented x 3, frail, thin *Otherwise unremarkable.* *Labs and images reviewed.* **Assessment/Plan:** • Elevated BNP • Dyspnea	15-20

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		• CP • HTN ER • Lactic Acidosis • Pulmonary Edema • CAD • PAF • CAS • SSS s/p DPPM • CVA, history No overt CHF symptoms but BNP elevation and pulmonary edema warrants repeat ECHO Hold GDMT in the setting hypotension resume low dose Coreg when able Rate controlled AF, continue dig, Eliquis, Plavix 1st trop (-), pt with prior PCI, residual 50-60% RCA on LHC last year **Dispo:** Medications as above, further recs after ECHO available for review. *XXXX, M.D.* **@ 1926 hours: Addendum:** I have seen and examined patient on 12/28/YYYY, and agree with above note. I have reviewed any labs/meds/cardiac imaging.	
12/28/YYYY	Hospital/ Provider Name	**@ 1419 hours: Progress Notes:** **Subjective:** Patient is seen for follow-up. When I saw her early in the morning patient told me she was feeling much better. She is breathing a lot easier. However towards the afternoon she reported having difficulty breathing. She also reported chest pain. Her blood pressure dropped to systolic in the 80s but responded with IV fluids. **Review of systems:** 10 system review negative except as noted above. **Objective:** **Vitals:** Temperature: 36.4 C, HR: 68, RR: 24, BP: 135/73, SpO2: 98%, oxygen method: Nasal cannula, weight: 49.206 kg (108.5 lb) **Physical examination:** **General:** Patient is awake and alert. Patient does not appear to be in any distress and is cooperative. Patient is oriented by 3. **Chest:** Reduced air entry bilaterally. *Otherwise unremarkable.* **Assessment/plan:** • Severe sepsis present on admission • COPD with exacerbation • Pneumonia • Volume overload • Lactic acidosis	148-151

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		• Acute on chronic hypoxemic respiratory failure • Hypotension **Plan:** • Rocephin and Zithromax. • ID consult • Cardiology consult. • Supplemental oxygen. Wean as tolerated • Hold antihypertensives. • Gentle rehydration • Continue other home medications.	
12/28/YYYY	Hospital/ Provider Name	**@ 1956 hours: Nursing Progress Notes:** Pt calm and cooperative, up x 1 BSC, attended to Pt needs, medicated per flowchart. Gave Pt morning meds at approx 0900 according to MAR. Shortly after Pt c/o of not feeling well, we again discussed the meds I had given and Pt said, "oh no, I had stopped taking the Lisinopril". Notified Dr. XXXX and monitored BP, gave bolus and trendelenburg, BP improved. Reviewed Pt med list with daughter and made adjustments. Cards was consulted, ordered an echo w/ spectral Doppler, awaiting test. Continue to monitor Pt. Report to oncoming RN.	533
12/29/YYYY	Hospital/ Provider Name	**@ 0335 hours: Nursing Progress Notes:** Pt frustrated at the start of shift due to Coreg being discontinued. RN explained that BP dropped earlier in the day and we are being cautious. Checked BP every few hours overnight. Pt did not feel well this morning and was concerned about BP. PRN dose Clonidine given for SBP 161.	533
12/29/YYYY	Hospital/ Provider Name	**@ 0348 hours: Labs:** **High:** Potassium: 5.5, glucose: 136, BUN: 28, BUN/creatinine ratio: 35 **Low:** CO2: 18, EGFR: 75, calcium: 8.4, albumin: 3.3 **Normal:** WBC: 8.7, RBC: 4.20, hemoglobin: 13.0, hematocrit: 39.6	764, 766
12/29/YYYY	Hospital/ Provider Name	**@ 0822 hours: Infectious Disease Consultation Report:** **Referring Physician:** Dr. XXXX **Reason for Consultation:** Antibiotic recommendations **History of present illness:** This is an 82-year-old female who is hard of hearing with history of COPD, sleep apnea, atrial fibrillation along with coronary artery disease status post angioplasty with history of prior MI x 3 along with hypertension CVA who presents to the emergency room after being brought in by EMS for chest pain and shortness of breath. She was given Aspirin on her way to the hospital. She did not have any fever or chills or any cough or congestion at the time of presentation. No nausea or vomiting. No diarrhea or constipation. A lot of the history was obtained from patient's chart, primary team and nursing staff as patient is currently sleeping and is hard of hearing. She dropped her systolic blood pressure to 88 yesterday and responded to IV fluids. She does not have any leukocytosis but had lactic acidosis of 3.32 days ago. Her troponins have been negative here. Her urine analysis was negative. Her	10-15

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		nasopharyngeal swab for COVID, influenza and RSV were negative. Her blood cultures have remained negative. She was started on Ceftriaxone and Zithromax as her chest X-ray was concerning for pneumonia in the left lung base. Infectious disease service was consulted for further antibiotic recommendations. **Review of systems:** 14 point review of system could not be obtained as the patient is sleeping and is hard of hearing. **Objective** **Vitals & Measurements:** Temperature: 36.5 °C (Oral), HR: 66, BP: 161/77, SpO2: 95%, Oxygen Method: Nasal cannula **Physical examination:** *Unremarkable.* *Labs and images reviewed.* **Assessment/Plan:** **Left basilar pneumonia:** Possibly community-acquired. Check Streptococcus pneumoniae urine antigen along with Legionella urine antigen. Check respiratory multiplex along with a swallow evaluation. On Ceftriaxone and Azithromycin. Monitor for antibiotic side effects. **Hypotension:** Had 1 episode yesterday. Status post fluid resuscitation. Improved. **Transaminitis:** Follow LFTs closely **COPD with possible exacerbation:** Continue current antibiotics. Steroids as per primary team Deconditioning. **Lactic acidosis:** Follow lactic acid levels closely Patient's treatment plan was discussed in detail with the primary team along with the nursing staff. Agree with the plan. Thank you for this consultation.	
12/29/YYYY	Hospital/ Provider Name	**@ 0859 hours: Cardiology Progress Notes:** **Subjective:** Pt seen and examined. No events overnight. Chart and telemetry reviewed. Discussed with RN. Pending ECHO, low dose Coreg resumed this AM as BPs elevated. **Review of systems:** *All systems reviewed and are negative.* **Objective:** **Vitals:** Temperature: 36.4C, HR: 93, BP: 146/74, SpO2: 92%, oxygen method:	145-147

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Room air **Physical examination:** **General:** No acute distress, alert and oriented x 3, thin *Otherwise unremarkable.* **Assessment/Plan:** • Elevated BNP • Dyspnea • CP • HTN ER • Lactic Acidosis • Pulmonary Edema • CAD • PAF • CAS • SSS s/p DPPM • CVA, history No overt CHF symptoms but BNP elevation and pulmonary edema warrants repeat ECHO GDMT held in the setting hypotension, now hypertensive, resume Coreg at lower dose Rate controlled AF, continue Dig, Eliquis, Plavix Trop (-) x 2, pt with prior PCI, residual 50-60% RCA on LHC last year **Disposition:** Medications as above, further recs after ECHO available for review.	
12/29/YYYY	Hospital/ Provider Name	**@ 1229 hours: Progress Notes:** **Subjective:** Patient is seen for follow-up. Her blood pressure was apparently markedly elevated in the course of the management earlier today. Cardiologist has restarted Coreg but at a lower dose. No fever or chills. Patient is doing well on room air. No nausea or vomiting. **Review of Systems:** Review negative except as noted **Objective:** **Vitals:** Temperature: 36.6C, HR: 86, RR: 18, BP: 134/54, SpO2: 94%, oxygen method: Room air **Assessment/plan:** • Hypotension resolved • Chronic hypertension **Plan:** • Echocardiogram ordered by cardiology today • Restart Lasix 20 mg PO daily	141-145

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Others remain same.	
12/29/YYYY	Hospital/ Provider Name	**@ 1500 hours: Transthoracic Echocardiogram:** **Ordering MD:** XXXX, M.D. **Indications:** Dyspnea **Study data:** Comparison was available for the study of 04/30/YYYY. **Study status:** Routine. **Patient status:** Inpatient. **Location:** Bedside. **Procedure:** Transthoracic echocardiography. Image quality was adequate. The study was technically limited due to body habitus. **Study completion:** The patient tolerated the procedure well. There were no complications. **Body surface area:** 1.54m^2. **Body mass index:** 17.6kg/m^2. **Cardiac Anatomy** **Left ventricle:** The cavity size is normal. Wall thickness was increased in a pattern of mild LVH. The estimated ejection fraction was in the range of 40% to 45%. Mild diffuse hypokinesis. Wall motion score: 2.00. Doppler parameters are consistent with a reversible restrictive pattern, indicative of decreased left ventricular diastolic compliance and/or increased left atrial pressure (grade 3 diastolic dysfunction). **Right ventricle:** Pacer wire or catheter noted in right ventricle. Systolic function is normal. Systolic pressure was within the normal range. The estimated peak pressure was 26mm Hg. **Left atrium:** The atrium is normal in size. **Right atrium:** The atrium is normal in size. **Ventricular septum:** The septum is in intact by color doppler. **Atrial septum:** The septum is in intact by color doppler. **Mitral valve:** The posterior annulus and leaflet is moderately calcified. **Doppler:** There is no evidence for stenosis. There is mild regurgitation. **Tricuspid valve:** Structurally normal valve. **Doppler:** There is trivial regurgitation. **Aortic valve:** Trileaflet. The leaflets were mildly calcified. **Doppler:** There is no stenosis. There is no significant regurgitation. **Pulmonic valve:** Structurally normal valve. **Doppler:** There is trivial regurgitation. **Aorta:** Aortic root: The aortic root is normal in size. **Ascending aorta:** The ascending aorta is normal in size. **Aortic arch:** The aortic arch is normal in size.	30-38, 483-491

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Systemic veins: **Inferior vena cava:** The vessel was normal in size. The respirophasic diameter changes were blunted (< 50%). The internal diameter is 2.0cm. **Pericardium:** A prominent pericardial fat pad was present. There is no pericardial effusion. **Study Conclusions:** **Left ventricle:** The cavity size is normal. Wall thickness was increased in a pattern of mild LVH. The estimated ejection fraction was in the range of 40% to 45%. Mild diffuse hypokinesis. Doppler parameters are consistent with a reversible restrictive pattern, indicative of decreased left ventricular diastolic compliance and/or increased left atrial pressure (grade 3 diastolic dysfunction). **Mitral valve:** The posterior annulus and leaflet is moderately calcified. There is mild regurgitation. **Right ventricle:** Pacer wire or catheter noted in right ventricle. Systolic function is normal. Systolic pressure was within the normal range. The estimated peak pressure was 26mm Hg.	
12/29/YYYY	Hospital/ Provider Name	**@ 1947 hours: Nursing Progress Notes:** Pt calm and cooperative, BP improvements. Pt is blind in left eye and now c/o diminished vision in right eye. Echo completed at bedside. Cards consulted. Continue to monitor Pt. Report to oncoming RN.	533
12/30/YYYY	Hospital/ Provider Name	**@ 0611 hours: Labs:** **High:** Glucose: 139, BUN: 31, BUN/creatinine ratio: 42 **Low:** CO2: 17, EGFR: 81, calcium: 8.3	765-766
12/30/YYYY	Hospital/ Provider Name	**@ 0731 hours: X-Ray of Chest:** **Ordering provider:** XXXX, M.D. **Comparison:** X-ray of chest dated 12/27/YYYY at 1142 hours. **Provided indications:** CHF **Findings/impression:** Granuloma involving the right upper lobe, calcified mediastinal lymph nodes. No acute infiltrate. No pneumothorax. Normal appearing cardiac silhouette with atrial biventricular pacemaker leads in place. Small right pleural effusion.	762
12/30/YYYY	Hospital/ Provider Name	**@ 0846 hours: Cardiology Progress Notes:** *XXXX, AGACNP* **Subjective:** Pt seen and examined. No events overnight. Chart and telemetry reviewed. Discussed with RN. Intermittent CP, random, at rest **Objective:** **Vitals:** Temperature: 36.6 C, HR: 80, RR: 18, BP: 155/90, SpO2: 96%, oxygen method: Room air	138-141

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment/plan: Worsening LVEF, ongoing diuresis GDMT held in the setting hypotension, now hypertensive, uptitrating Coreg Rate controlled AF, continue Dig (every other day), Plavix, hold Eliquis given planned for LHC on this admission, start full dose Lovenox this PM Trop (-) x 2, pt with prior PCI, residual 50-60% RCA on LHC last year, new cardiomyopathy & CP, plan for LHC this admission **Dispo:** Medications as above, plan for LHC Monday or Tuesday *XXXX, M.D.* **Addendum:** Chart reviewed, agree with above. AF, rate controlled. Increasing Coreg for hypertension. Continue diuresis. Starting Lovenox due to anticipated LHC this admission. *Others remain same.*	
12/30/YYYY	Hospital/ Provider Name	**@ 0855 hours: Speech Therapy Record – Swallow Evaluation:** Fall risk Peripheral IV Hard of hearingVisual deficits **Rehab Potential and Diagnosis** **Assessment** **Precautions/Contraindications:** Fall risk Peripheral IV Hard of hearing Visual deficits **Treatment Diagnosis for ST:** Evaluate for dysphagia **Medical Necessity Justification (ST):** Minimize aspiration risk **Assessment Swallow** **Recommended Diet Texture:** Level 7 Regular Diet **Recommended Liquid Consistencies:** Level 0 thin liquids **Swallowing Precautions:** Sit at 90° in chair or in chair position, Small bites/sips, Alternate liquids/solids, Other: medications as tolerated **Narratives** **Objective** Pt seen for a Clinical Swallow Evaluation which was initiated at 0855: Cumulative time spent completing evaluation process was 100 minutes. Clinical discussion completed with RN prior to and after session. Pt was pleasant and cooperative. Seated upright in bed for the session. RN present for medication administration. Per Cerner documentation: Temp 36.6; 94% O2 saturation on room air; breath sounds are diminished. Pt reported being hard of hearing and with vision deficits. Pt was trialed with ice chips, thin liquid, puree, and solids. No overt s/s of aspiration noted with trials. Clear vocal quality noted with trials. Slow yet adequate mastication and clearance of boluses. Impressions and recommendations discussed with pt, and RN after evaluation. Swallow precautions posted at bedside with diet recommendations.	548-551

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment Pt presents with a functional swallow response without overt s/s of aspiration. Slow mastication due to no lower dentition however, adequate clearance of boluses. Pt had timely swallow response and was able to clear boluses without c/o globus sensation. Brisk hyolaryngeal movement per manual palpation. Recommend continuing on her current diet of Level 7 Regular and thin liquids. Unable to rule out silent aspiration at bedside. IF there is a concern for silent aspiration, consider ordering an instrumental swallow study. Otherwise, no further SLP f/u warranted at this time. No noted cognitive or speech production deficits during session. Pt reports feeling close to baseline function. **Recommendations:** Regular diet/thin liquids Standard swallow precautions: upright for all PO, slow rate, small bites/sips No anticipated SLP needs at discharge No further SLP follow-up warranted at this time. **Historical Rehab Info** **History of Present Illness:** 84 year old female presented with shortness of breath, congestive heart failure, COPD exacerbation and hypertensive emergency. Being treated for sepsis. **Past Medical History - Rehab:** COPD, Sleep apnea, Afib, CAD s/p stent placements, prior MI x3, HTN, CVA with residual right sided deficits, glaucoma **Date/Onset of Injury/Limitation:** 12/27/YYYY **Social History (rehab)** **Lives In:** Mobile home **Living Situation:** Lives with family **Home Access:** Trailer with 3 steps to enter with one R sided rail when ascending; pt holds doorknob and daughter assists. Also ramp entry available. Tub-shower with shower chair and grab bar. Step to get in bathroom. **Preferred Language for Healthcare:** English **PLOF (rehab)** **Additional PLOF Info (Rehab):** Pt reported tolerating a regular diet with thin liquids at baseline **Objective Assessments** **Oral Peripheral Exam** **Labial Information:** Asymmetry right weakness **Lingual Function:** Asymmetry right weakness **Mandibular Function:** WDL **Dentition:** Dentures, Other: upper dentures, missing lower dentures **Velar Elevation:** WDL **Vocal Quality (pre-p.o.):** WDL **Spontaneous Cough:** Not Observed **Volitional Cough:** WDL	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Volitional Throat Clearing: WDL **Volitional Swallow:** WDL **Clinical Swallow Evaluation** **Additional Swallow Function Info:** Pt was seen with PO trials which she self fed with her left hand but also asked for assistance at times. **Consistency:** Ice chips **Presentation/Amount:** Bite size **Compensatory Strategies:** None **Oral Phase Response:** WFL **Pharyngeal Phase Response Swallow:** Possible delayed pharyngeal response **Consistency:** Level 0 thin liquids **Presentation/Amount:** Small sips from cup, Large consecutive swallows, Straw **Compensatory Strategies:** None **Oral Phase Response:** Delayed bolus transfer **Pharyngeal Phase Response Swallow:** Possible delayed pharyngeal response **Consistency:** Level 4 Pureed Dysphagia Diet **Presentation/Amount:** 1/2 Teaspoon, Teaspoon **Compensatory Strategies:** None **Oral Phase Response:** Delayed bolus transfer **Pharyngeal Phase Response Swallow:** Possible delayed pharyngeal response **Consistency:** Level 7 Regular Diet **Presentation/Amount:** Bite size **Compensatory Strategies:** None **Oral Phase Response:** Delayed bolus transfer, Prolonged mastication **Pharyngeal Phase Response Swallow:** Possible delayed pharyngeal response **Swallow Recommendations** **Recommended Diet Texture:** Level 7 Regular Diet **Recommended Liquid Consistencies:**- Level 0 thin liquids **Swallowing Precautions:** Sit at 90° in chair or in chair position, Small bites/sips, Alternate liquids/solids, Other: medications as tolerated. **Treatment** **ST Treatment Duration:** Eval only - no further treatment **Therapy** **Discharge Recommendations** **ST DC Recommendations:** Therapy discharge recommendations are made by determining the patient's prior level of function, assessing current functional level, and establishing rehab potential. The overall discharge plan may be affected by input from Physicians, Care Coordination, medical condition/status,	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		family support, and insurance benefits., Discharge Home/Prior Living Situation with no further follow-up. Patient at baseline level of functioning. **Swallowing Precautions:** Sit at 90° in chair or in chair position, Small bites/sips, Alternate liquids/solids, Other: medications as tolerated **Education** **Teaching Method:** Explanation **Response to Teaching:** Communicated understanding **Preferences to Learning:** Any/all **Readiness to Learn:** Accepting **Barriers to Learning:** None evident **ST Education Provided For:** Swallowing strategies, Other: Plan of care, recommendations, aspiration risk, swallow precautions **Individuals Taught by ST:** Patient	
12/30/YYYY	Hospital/ Provider Name	**@ 1419 hours: Infectious Disease Progress Notes:** **Subjective:** Eating her meal **Vitals:** (see table below)	135-138

Time	Temperature	HR	RR	NIBP	NIBP mean	SaO2
12/29/YYYY						
0600	-	65	-	-	-	-
1841	36.4	-	-	127/72	-	-
1912	36.6	86	-	-	81	-
2021	-	-	18	-	-	94
2320	-	-	-	177/93	121	-
12/30/YYYY						
0859	-	-	-	150/78	102	-
0900	-	-	-	-	-	99
0907	-	82	-	-	-	-

Weight:
12/27/YYYY at 1100 hours: Admit: 54.42 kg
12/27/YYYY at 2133 hours: Current: 49.21 kg
Gain/loss: -5.22

Physical examination: *Unremarkable.*

Assessment/Plan:
Left basilar pneumonia: Possibly community-acquired. Await Streptococcus pneumoniae urine antigen along with Legionella urine antigenrespiratory multiplex along with a swallow evaluation. On Ceftriaxone and Azithromycin. Monitor for antibiotic side effects.

Positive HIV test: Confirmatory test to be done

D/W patient/primary team/RN in detail.

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Others remain same.	
12/30/YYYY	Hospital/ Provider Name	**@ 1512 hours: Internal Medicine Progress Notes:** **Subjective:** **Patient Complaint:** Pt lying in bed resting in NAD. Pt denies any pain complaints this AM. She denies any fever/chills, diarrhea/constipation or nausea/vomiting. Pt states she still does feel SOB. **Review of systems:** *All systems reviewed and are negative.* **At 1200 hours: Vitals:** Temperature: 36.4C, HR: 91, NIBP: 160/97, NIBP mean: 110, SaO2: 93 **Physical examination:** **Respiratory:** Respirations are non-labored, mild coarse BS bilaterally **Extremities:** **Upper Extremities:** Bilateral, Edema (None). **Lower Extremities:** Bilateral, Edema (None). **Impression and Plan:** **Plan:** **Sepsis** • 2/2 PNA • Continue CTX/Azithromycin • Appreciate ID recs **COPD with exacerbation** • Duonebs PRN • Continue steroids **CAP** • Continue CTX/Azithromycin **Acute on chronic hypoxemic respiratory failure** • Continue NC • Wean as tolerated **Chronic hypertension** • Continue Carvedilol **PAF** • Continue Dig/Plavix • Continue Lovenox **HIV positive** • Await confirm testing	128-135
12/31/YYYY	Hospital/	**@ 0449 hours: Labs:**	765-766

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
	Provider Name	**High:** Glucose: 193, BUN: 38, BUN/creatinine ratio: 51 **Low:** Anion gap: 6, EGFR: 79, calcium: 8.4	
12/31/YYYY	Hospital/ Provider Name	**@ 0953 hours: Cardiology Progress Notes:** *XXXX, AGACNP* **Subjective:** Pt seen and examined. No events overnight. Chart and telemetry reviewed. Discussed with RN. Initial HIV testing (+), awaiting confirmatory testing. BP still elevated, adding PO Hydralazine. **Objective:** **Vitals:** Temperature: 36.7C, HR: 59, RR: 16, BP: 174/83, SpO2: 95%, oxygen method: Room air **Assessment/plan:** Worsening LVEF, ongoing diuresis GDMT held in the setting hypotension, now hypertensive, uptitrating Coreg, no room for higher dose given HR, add PO Hydralazine, uptitrate as needed Rate controlled AF, continue Dig (every other day), Plavix, hold Eliquis given planned for LHC on this admission, on full dose Lovenox this PM Trop (-) x 2, pt with prior PCI, residual 50-60% RCA on LHC last year, new cardiomyopathy & CP, plan for LHC this admission *XXXX, M.D.* **@ 1306 hours: Addendum:** Chart reviewed, agree with above. Continue current Rx including diuresis. Plan for LHC Monday/Tuesday. *Others remain same.*	125-128
12/31/YYYY	Hospital/ Provider Name	**@ 1321 hours: Progress Notes:** **Subjective:** Patient is seen today for follow-up. She feels well. She has no fever or chills. No nausea or vomiting. She has been eating well. **Objective:** **Vitals:** Temperature: 36.7C, HR: 60, RR: 16, BP: 157/74, SpO2: 95%, oxygen method: Room air **Physical examination:** **HEENT:** Patient is hard of hearing **Chest:** Reduced air entry bilaterally **Assessment/plan:** **Pulmonary vascular congestion:** • Patient is scheduled for left heart catheterization • Continue gentle diuresis *Others remain same.*	120-125

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<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td>12/31/YYYY</td><td>Hospital/
Provider Name</td><td>
@ 1411 hours: Infectious Disease Progress Notes:
Subjective: No fever.

Vitals:
<table>
<tr><th>Time</th><th>Temperature</th><th>HR</th><th>RR</th><th>NIBP</th><th>NIBP mean</th><th>SaO2</th></tr>
<tr><td colspan="7">12/30/YYYY</td></tr>
<tr><td>1200</td><td>36.4</td><td>-</td><td>-</td><td>-</td><td>-</td><td>93</td></tr>
<tr><td>1600</td><td>36.7</td><td>-</td><td>-</td><td>-</td><td>126</td><td>97</td></tr>
<tr><td>1700</td><td>-</td><td>105</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>YYYY</td><td>-</td><td>-</td><td>-</td><td>136/71</td><td>93</td><td>-</td></tr>
<tr><td>2120</td><td>-</td><td>-</td><td>16</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td colspan="7">12/31/YYYY</td></tr>
<tr><td>0457</td><td>-</td><td>-</td><td>-</td><td>180/81</td><td>-</td><td>-</td></tr>
<tr><td>0800</td><td>36.5</td><td>-</td><td>18</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>0818</td><td>-</td><td>59</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>1358</td><td>-</td><td>72</td><td>-</td><td>159/66</td><td>97</td><td>96</td></tr>
</table>

Physical examination:
Chest: Crackles in the lower zones
Cardiac: S1S2 heard
Otherwise unremarkable.

Assessment/plan:
Hypotension: Resolved. Status post fluid resuscitation. Improved.

Others remain same.
</td><td>117-120</td></tr>
<tr><td>12/31/YYYY</td><td>Hospital/
Provider Name</td><td>
@ 1516 hours: Nursing Progress Notes:
Pt calm and cooperative, daughter at bedside, Pt able to self-turn, attended to Pt needs, medicated per flowchart. Pt receives scheduled breathing treatments as well as PRN. Closely monitoring BP. XXXX, NP Cards ordered Hydralazine 25mg PO, Pt concerned about taking it, Mary said ok to hold if SBP > 160, "it won't cause her BP to drop drastically." Pt agreed to take med. Mary will order NPO for tonight, if left heart cath does not take place in morning then will allow Pt to eat and place NPO Mon night for Tues procedure. Pt and daughter aware. Continue to monitor Pt. Report to oncoming RN.
</td><td>532-533</td></tr>
<tr><td>01/01/YYYY</td><td>Hospital/
Provider Name</td><td>
@ 0640 hours: Labs:
High: Glucose: 144, BUN: 28, BUN/creatinine ratio: 44
Low: Anion gap: 6, EGFR: 88, calcium: 8.4
</td><td>765-766</td></tr>
<tr><td>01/01/YYYY</td><td>Hospital/
Provider Name</td><td>
@ 1213 hours: Cardiology Progress Notes:
XXXX, AGACNP
Subjective:
Pt seen and examined. No events overnight. Chart and telemetry reviewed. Discussed with RN.
Pending LHC tomorrow. Intermittent CP. Family @ bedside.

Review of systems:
</td><td>114-117</td></tr>
</table>

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Cardiovascular: + chest pain, palpitations, syncope **Objective:** **Vitals:** Temperature: 36.3C, HR: 76, RR: 18, BP: 144/69, SpO2: 97%, oxygen method: Room air **Disposition:** Medications as above, NPO after midnight for LHC in AM. *XXXX, M.D.* **At 1234 hours: Addendum:** Chart reviewed, agree with above. Continue diuresis. Plan for LHC tomorrow. *Others remain same.*	
01/01/YYYY	Hospital/ Provider Name	**@ 1229 hours: Blood Culture Report:** **Collected date:** 12/27/YYYY at 1142 hours **Final report:** No growth at 5 days	770
01/01/YYYY	Hospital/ Provider Name	**@ 1229 hours: Blood Culture Report:** **Collected date:** 12/27/YYYY at 1136 hours **Final report:** No growth at 5 days	771
01/01/YYYY	Hospital/ Provider Name	**@ 1302 hours: Progress Notes:** **Subjective:** Continues to complain of mild dyspnea. However able to speak in full sentences. **Objective:** **Vitals:** Temperature: 36.3C, HR: 76, RR: 18, BP: 144/69, SpO2: 97%, oxygen saturation: Room air **Physical examination:** **Lungs:** Decreased breath sounds bilaterally. No crackles or wheezes **Neuro:** Cranial nerves 2-12 grossly intact, no gross motor deficits, strength 5/5 bilateral upper and lower extremity large muscle groups, sensation grossly intact throughout to light touch. DTRs 2+ symmetric at biceps/triceps/knee/ankle. Toes downgoing bilaterally. Cerebellar: No dysmetria, gait not tested. *Others remain same.*	110-114
01/01/YYYY	Hospital/ Provider Name	**@ 1530 hours: Infectious Disease Progress Notes:** **Subjective:** No fever **Vitals:**	107-110

Time	Temperature	HR	RR	NIBP	NIBP mean	SaO2
12/31/YYYY						
1543	-	-	-	143/68	93	-
1600	-	97	-	-	-	-
2000	-	60	18	-	-	-
2300	36.6	-	-	167/72	-	-
01/01/YYYY						

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<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
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<tr><td>0400</td><td>-</td><td>-</td><td>-</td><td>-</td><td>-</td><td>93</td></tr>
<tr><td>0900</td><td>36.3</td><td>-</td><td>18</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>0904</td><td>-</td><td>-</td><td>-</td><td>-</td><td>105</td><td></td></tr>
<tr><td>1057</td><td>-</td><td>76</td><td>-</td><td>144/69</td><td>94</td><td>97</td></tr>
</table>

Physical examination:
General: No distress
Extremities: Trace lower extremity edema
Otherwise unremarkable.

Assessment/plan:
Left basilar pneumonia: Possibly community-acquired. Streptococcus pneumoniae urine antigen along with Legionella urine antigen, respiratory multiplex negative. Appreciate speech therapy evaluation. On Ceftriaxone and Azithromycin. Monitor for antibiotic side effects.

Others remain same.
</td><td></td></tr>
<tr><td>01/01/YYYY</td><td>Hospital/ Provider Name</td><td>
@ 1706 hours: Nursing Progress Notes:
Pt calm and cooperative, Pt able to self-turn, attended to Pt needs, medicated per flowchart. Pt x 1 asst BSC, had large BM. Pt receives scheduled breathing treatments as well as PRN. Closely monitoring BP. XXXX, NP Cards ordered Hydralazine 25mg PO, "okay to hold if SBP <160". Pt will be NPO tonight, for left heart cath procedure tomorrow. Pt and daughter aware. Continue to monitor Pt. Report to oncoming RN.
</td><td>532</td></tr>
<tr><td>01/02/YYYY</td><td>Hospital/ Provider Name</td><td>
@ 0902 hours: Procedure Report:
Cardiac catheterization report:
Indication for procedure: New onset systolic congestive heart failure in a patient with known coronary artery disease.
Preoperative diagnosis: New onset systolic congestive heart failure in a patient with known coronary artery disease.
Postoperative diagnosis: Coronary artery disease-non-obstructive.
Anesthesia: Local anesthesia with moderate conscious sedation.
Vascular access hemostasis: With the help of manual pressure.

Procedures performed:

Left heart catheterization, selective coronary angiography.
Left ventriculography.
Moderate conscious sedation.

Procedure details: Written informed consent was obtained from the patient explaining risks, benefits, and alternatives. Subsequently, the patient was prepped and draped in usual sterile fashion.

Moderate conscious sedation was given with the help of intravenous Versed and Fentanyl. The patient's hemodynamics were monitored throughout the duration of the procedure for a total of 45 minutes by independent trained observers in the cardiac cath lab.
</td><td>50-63</td></tr>
</table>

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Access was obtained to the right common femoral artery, as the patient had a prior stroke and unable to straighten the right elbow, therefore, right common femoral arterial access site was used. Using ultrasound guidance, access to the right common femoral artery access site was confirmed to below the inferior epigastric and above the bifurcation before upgradation to a 6-French sheath. Selective coronary angiography of the left coronary system was performed with the help of a JL4 diagnostic catheter and right coronary system performed with the help of a JR4 diagnostic catheter. The following findings were noted. **Findings:** Left main coronary artery is a large-sized vessel, divides in the usual fashion into LAD and left circumflex coronary artery. The left main coronary artery is free of any significant disease angiographically. Left anterior descending artery is a large-sized vessel. Stent is seen in the proximal left anterior descending artery, which is widely patent. The LAD then gives rise to diagonal 1 vessel and wraps all the way to the apex of the heart and into the posterior interventricular groove supplying the inferior wall as well. Left circumflex coronary artery is a small size vessel, runs into the AV groove branch, gives rise to obtuse marginal 1, has minor luminal irregularities, small size vessel. Right coronary artery has anterior takeoff. Stents are noted in the mid right coronary artery, small-sized right coronary artery, divides into PDA and PLV. The stent in the right coronary artery is widely patent. After the stented segment, there is 40% diffuse stenosis noted. The posterior descending artery and the posterior lateral branch are small-sized vessels. Vascular access hemostasis with the help of manual pressure with a small-sized vessel and calcification noted on the angiogram. **Conclusion:** The patient has patent LAD and RCA stents. No change in anatomy since prior angiogram. Continue maximal directed medical therapy for systolic congestive heart failure.	
01/02/YYYY	Hospital/ Provider Name	**@ 1004 hours: Physician Note:** No angiographic evidence of obstructive coronary artery disease patent LAD and RCA stent.	106-107
01/02/YYYY	Hospital/ Provider Name	**Nursing Progress Notes:** *Sequenced per content* Patient arrived to unit at approximately 1050. Assessed right groin puncture site with Emily D, RN. No bleeding, no firm areas or protrusions. Received call from Rilea, RN at 1139 to assist with assessment of patient. Pt reported to this RN "I feel like I'm going to pass out! I can't breathe, I'm in pain". Assessed right groin site, no bleeding however right lower abdomen is firm and painful to touch. Softball sized "hematoma" of right abdomen. Checked patient's eyelids and	532

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		tongue. Eyelids are pale, tongue is cyanotic. Patient desaturated to 77 off oxygen. Attempted to obtain BP at multiple sites. Contacted Resource RN and Charge RN, rapid response called. Attempted to contact MD, unsuccessful. House Manager, RRT came to bedside to assist. Patient became increasingly drowsy and increasingly difficult to rouse. Spoke with Dr. XXXX and Reported findings and Dr. XXXX stated "Why did you call a rapid response?!". Reiterated that nobody was able to contact him directly and patient had changes in vitals, increasing pain and developing hematoma. Right LE difficulty finding pulses. Doppler used, pulses found on dorsal ped, right popliteal. Dr. XXXX ordered for patient to be brought to cath lab. SWAT RN escorted patient to cath lab. Anita RN called this Rilea RN and this RN overheard report. Anita stated "Patient didn't have anything there, it was just urine. She will need to be straight cath and before any procedures, she should have gone to the bathroom. Informed Anita RN that patient voided prior to cath lab. Cardiac RN contacted Rilea RN and reported that patient did have additional cath on right side and new cath on left side. There was a hematoma on right side. Patient was to remain in recovery for 2 hours prior to being transported back to unit.	
01/02/YYYY	Hospital/ Provider Name	**@ 1230 hours: Procedure Report:** **Cardiac catheterization report:** **Indication for procedure:** The patient having low blood pressure and possible hematoma concern for retroperitoneal hematoma. Therefore, the patient was emergently brought to the cardiac catheterization lab. **Procedure performed:** Aortoiliac angiography with selective right iliac artery angiography. **Procedure in detail:** Access obtained to the left common femoral artery using ultrasound guidance. Access site confirmed to be below inferior epigastric and above the bifurcation before upgrading to a 5-French sheath. Subsequently, we used contralateral catheter, and crossover catheter to cross over to the contralateral iliac artery. Subsequently, selective left iliac angiography was performed which showed minor PAD on the right iliac angiography. However, there was no contrast extravasation noted either in the internal or external iliac artery or in the common femoral artery. The patient is hemodynamically stable. Left Femoral arterial access vascular access closure was done with the help of a 5/6-French Mynx device no hematoma.	41-49
01/02/YYYY	Hospital/ Provider Name	**@ 1212-1235 hours: Rapid Response Team:** **RRT activation and response:** **Primary Call Reason:** Staff concern/worried **SBAR:** **At 1212 hours:** RRT called for concern for L heart cath. R groin site and R abdominal swelling/tenderness. **At 1222 hours:** SWAT at bedside. Able to palpate weak pedal pulses; cap refill <3; vitals stable. Pt C/O 10/10 pain. Vitals on Iview. **At 1223 hours:** Orders to return to cath lab. **At 1225 hours:** In transport to cath lab on portable monitor with RNx3 and pt	535

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<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>daughter.
At 1233 hours: Dr. XXXX at bedside in cath lab assessing pt.
At 1235 hours: Left stable pt in care of cath lab team

RRT Called: At 1212 hours
Interventions: Monitor/Tele, Nasal cannula
RRT RN Arrival: At 1222 hours
RT Arrival: At 1222 hours
Physician Called: At 1222 hours

Provider Name: Upamanyu XXXX, M.D.

Labs/Diagnositics: None
Outcomes: Other: transport to cath lab

Pediatric Sepsis Screening Tool - Inpatient
SIRS Infection Peds: Adult</td><td></td></tr>
<tr><td>01/02/YYYY</td><td>Hospital/ Provider Name</td><td>**@ 1331 hours: Physician Note:**
Left CFA access,
No evidence of contrast extravasation in the left external iliac or left common femoral artery.

No hematoma noted as well likely patient having pain from distended urinary bladder. Noninvasive blood pressure reading in the left arm should be done, she has left iliac artery stenosis, will have falsely low BP in lower extremity.</td><td>106</td></tr>
<tr><td>01/02/YYYY</td><td>Hospital/ Provider Name</td><td>**@ 1403 hours: Infectious Disease Progress Notes:**
Subjective: Status post cardiac catheterization.

Vitals:
<table>
<tr><th>Time</th><th>Temperature</th><th>HR</th><th>RR</th><th>NIBP</th><th>NIBP mean</th><th>SaO2</th></tr>
<tr><td colspan="7">**01/01/YYYY**</td></tr>
<tr><td>1300</td><td>-</td><td>82</td><td>-</td><td>-</td><td>-</td><td>86</td></tr>
<tr><td>1546</td><td>-</td><td>-</td><td>-</td><td>-</td><td>90</td><td>-</td></tr>
<tr><td>1723</td><td>-</td><td>-</td><td>-</td><td>-</td><td>107</td><td>-</td></tr>
<tr><td>1936</td><td>36.8</td><td>-</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td colspan="7">**01/02/YYYY**</td></tr>
<tr><td>0000</td><td>36.4</td><td>-</td><td>18</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>0500</td><td>36.5</td><td>-</td><td>18</td><td>171/85</td><td>-</td><td>-</td></tr>
<tr><td>1050</td><td>-</td><td>-</td><td>-</td><td>-</td><td>104</td><td>-</td></tr>
<tr><td>1052</td><td>-</td><td>61</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
<tr><td>1200</td><td>-</td><td>-</td><td>-</td><td>99/53</td><td>-</td><td>-</td></tr>
<tr><td>1225</td><td>-</td><td>62</td><td>-</td><td>121/77</td><td>-</td><td>100</td></tr>
</table>

Physical examination:
General: No distress
Chest: Basal crackles noted</td><td>103-105</td></tr>
</table>

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Extremities: Trace lower extremity edema *Otherwise unremarkable.* **Assessment/Plan:** **Left basilar pneumonia:** Possibly community-acquired. Streptococcus pneumoniae urine antigen along with Legionella urine antigen, respiratory multiplex negative. Appreciate speech therapy evaluation. Status post Ceftriaxone and Azithromycin. Monitor for antibiotic side effects. Discontinue antibiotics **CAD:** Cardiac catheterization done. Per cardiology service *Others remain same.*	
01/02/YYYY	Hospital/ Provider Name	**@ 1635 hours: Labs:** **High:** WBC: 18.9 **Low:** MCHC: 31.7 **Normal:** RBC: 4.25, hemoglobin: 12.3, hematocrit: 38.7, platelet: 325	764
01/02/YYYY	Hospital/ Provider Name	**@ 1826 hours: Progress Notes:** **Subjective:** Patient seen after LHC this morning. She was alert and oriented. However was informed by the nursing shortly thereafter the patient had abdominal pain. She was taken down to the Cath Lab right away to rule out possible complications of the LHC. Cardiology documentation noted about no evidence of leak Pt concerned about carotid artery stenosis. **Objective:** **Vitals:** Temperature: 36.5C, HR: 70, RR: 25, BP: 121/60, SpO2: 97%, oxygen method: Room air **Physical examination:** **Lungs:** Clear to auscultation bilaterally. No crackles or wheezes. **CV:** RRR, normal S1/S2, no gallops. PMI not displaced. No jugular venous distention. **Neuro:** Cranial nerves 2-12 grossly intact, no gross motor deficits, strength 5/5 bilateral upper and lower extremity large muscle groups, sensation grossly intact throughout to light touch. DTRs 2+ symmetric at biceps/triceps/knee/ankle. Toes downgoing bilaterally. Cerebellar: No dysmetria, gait not tested. **Assessment/plan:** **Pulmonary vascular congestion** • Patient is s/p LHC with no stent (LAD ?RCA) occlusion. • Continue gentle diuresis. *Others remain same.*	101-103
01/02/YYYY	Hospital/ Provider Name	**@ 2158 hours: EKG:** Sinus rhythm	39, 66

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Possible left atrial enlargement Left ventricular hypertrophy and ST-T change Abnormal ECG Compared to ECG 12/27/YYYY at 1108 hours Left ventricular hypertrophy now present	
01/03/YYYY	Hospital/ Provider Name	**@ 0228 hours: Nursing Progress Notes:** Pt complaining of chest pain, claiming heartburn, and nausea, EKG completed, no changes from baseline EKG, chest pain resolved. Pt refused meds due to nausea and refused new IV placement as current is infiltrated. Pt unable to void, bladder scan showing 585ml, pt straight cathed, 600mL out. Pt uncomfortable all night but refusing repositioning due to pain, stayed laying on right side. New IV placed by SWAT in AM, pt and family still refusing blood pressure medication stating they'd rather the pt be on home medications only, educated on importance of mediations ordered and rationale behind giving ordered meds due to procedures. Pt complaining of chest pain in AM stating she needs a breathing treatment to help, breathing treatment complete, chest pain resolved.	531-532
01/03/YYYY	Hospital/ Provider Name	**@ 0905 hours: Occupational Therapy Record – Initial Evaluation:** **Rehab Potential and Diagnosis:** **Assessment:** **Medical Necessity Justification (OT):** Impaired ADLs, balance, transfers, mobility **Treatment Diagnosis for OT:** ADL and transfer dysfunction **Precautions/Contraindications:** Fall risk Peripheral IV Hard of hearing Visual deficits **Rehabilitation Potential:** Good **Narrative:** **Objective:** OT orders received, chart reviewed and initial evaluation initiated at 0905. A total of 90 minutes to complete this high complexity evaluation including chart review, direct pt care and documentation. Upon arrival pt was sidelying towards R and agreeable to OT evaluation. Once session was complete pt was left semisupine in bed, fall mats in place, pillows arranged to promote joint protection, call light and tray in reach and bed alarm on for safety. Collaborated with PT and RN regarding mobility status and d/c rec's **Standardized test:** AM-PAC daily activity 11/24 indicating maximal A for ADLs **Assessment:** Pt is an 82 year old female presented with shortness of breath, congestive heart failure, COPD exacerbation and hypertensive emergency. Pt s/p left CFA access, no evidence of contrast extravasation in the left external iliac or left common femoral artery. Rapid response called post procedure 2/2 pt's report of pain. No hematoma noted likely patient having pain from distended urinary bladder. Minimal mobility completed this 2/2 pt's pain level. Pt overall not agreeable to most mobility attempts/recommendations 2/2 R sided pain. She agreed to	536-539

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		repositioning which required total Ax2 to successfully complete. In addition to mobility limitations pt with deficits in ADL management currently requiring max A for successful completion with notable active movement in RUE but overall reduce strength and ROM 2/2 previous session and thus pt relays on LUE to complete ADLs. As pt is presenting with multiple areas of functional limitations skilled OT intervention is recommended to continue to maximize functional independence as well as safety. Recommend post-acute setting to address impairments and maximize functional outcomes. The patient is able to tolerate 1-2 hours of therapy per day. The patient is reasonably expected to actively participate in and benefit from this level of therapy. **Historical Rehab Info** **Historic Info (rehab)** **History of Present Illness:** Pt is an 82 year old female presented with shortness of breath, congestive heart failure, COPD exacerbation and hypertensive emergency. Pt s/p left CFA access, no evidence of contrast extravasation in the left external iliac or left common femoral artery. Rapid response called post procedure 2/2 pt's report of pain. No hematoma noted likely patient having pain from distended urinary bladder. **Past Medical History - Rehab:** COPD, Sleep apnea, Afib, CAD s/p stent placements, prior MI x3, HTN, CVA with residual right sided deficits, glaucoma **Date/Onset of Injury/Limitation:** 12/27/YYYY **Social History (rehab)** **Lives In:** Mobile home **Living Situation:** Lives with family **Home Access:** Trailer with 3 steps to enter with one R sided rail when ascending; pt holds doorknob and daughter assists. Also ramp entry available. Tub-shower with shower chair and grab bar. Step to get in bathroom. **Preferred Language for Healthcare:** English **Additional Social History Info:** Pt reports she has a caregiver but needs more assistance/hours that have not been approved. Daughter assists as well but does work. **PLOF (rehab)** **Assistive Devices Used:** 3-in-1 Commode, Front wheel walker, Hospital bed, Manual wheelchair, Shower chair **Vision-PLOF:** Other: blind in L eye; low vision in R **Additional PLOF Info (Rehab):** Pt has a FWW but states she cannot use it 2/2 impaired ROM strength/ROM. She has a manual wheelchair, bedside commode, shower chair and hospital bed. Pt states she needs assistance for transfers and walking as well as ADLs. **Objective Assessments** **Functional Mobility** **Bed Mobility:** Dependent **Bed Mobility Details:** Total A for 2 to roll side<>side and reposition pt overall pt not agreeable to mobility attempts reporting her R side was too painful to	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		move. Pt was agreeable to have writer A in scooting her up in the bed and adjusting sheets to improve positioning. **General Transfer Details:** Deferred this date as pt was not agreeable **ADLs** **LB Dressing Details:** Total A to don socks **Toileting Details:** Purewick in place pt reporting she is having difficulty going to the bathroom and needed to be straight cathed. Reports abdominal pain similar to when her bladder was full last night; relayed to RN. **Self-Feeding:** Supervision **Self-Feeding Details:** Observed pt bring cup to mouth with LUE without difficulty. **Cognition/Vision/Perception** **CPV Status Details:** Pt was alert throughout today's session and agreeable to minimal therapy intervention this date. **Visual Motor Screen** **Overall Screen Assessment:** Baseline L eye blindness with low vision in R eye. **UE Status** **UE Status:** Impaired RUE, RUE Dominant **Additional Upper Extremity Status Info:** Baseline R sided weakness 2/2 prior stroke. Pt demonstrated ~30 degrees of active R shoulder flexion with minimal digit flexion/extension. Formal MMT deferred this date 2/2 reports of significant pain, worse compared to baseline. **Treatment:** **Treatment Duration:** Length of stay **Treatment Frequency: Other:** 2-4x/week **Intervention(s):** ADL training, Balance training, Compensatory strategies, Functional mobility training, Safety education, Therapeutic activities, Therapeutic exercises, Transfer training **TX Plan/Goals Est with Patient/Caregiver:** Yes **Plan for Next Session:** ADL and transfer training **Therapy** **Discharge Recommendations** **OT DC Recommendations:** Therapy discharge recommendations are made by determining the patient's prior level of function, assessing current functional level, and establishing rehab potential. The overall discharge plan may be affected by input from Physicians, Care Coordination, medical condition/status, family support, and insurance benefits., Pt. would benefit from 1-2 hrs multidisciplinary therapy/day upon d/c from acute care setting to assist with returning to prior level of functioning. **Education**	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Teaching Method: Explanation **Response to Teaching:** Communicated understanding **Preferences to Learning:** Any/all **Readiness to Learn:** Accepting **Barriers to Learning:** None evident **OT Education Provided for:** Safety, Therapy plan of care **Individuals Taught by OT:** Patient, Child	
01/03/YYYY	Hospital/ Provider Name	**@ 0905 hours: Physical Therapy Record Initial Evaluation:** **Rehab Potential and Diagnosis** **Assessment** **Precautions/Contraindications:** Fall risk; Peripheral IV; Hard of hearing; Visual deficits; Chronic R hemiparesis **Rehabilitation Potential:** Fair **Treatment Diagnosis for PT:** Impaired functional mobility, bed mobility, transfers, gait, balance, endurance, strength, safety Medical Necessity Justification (PT): training for functional mobility, bed mobility, transfers, gait, balance, endurance, strength, safety **Narratives** **Subjective** Pt agreeable to PT session. Spoke with RN prior to session. Pt states, "Don't touch my right side." **Objective** Order received, chart reviewed. Evaluation was started at 0905. Total time including chart review, direct patient care, communication with multi-disciplinary staff about discharge recommendations and documenting was 90 minutes. Pt seen in conjunction with Occupational Therapy to optimize patient safety, goals and overall functional performance. Discussed case with patient's nurse prior to entering room. Patient was received supine in bed, bed alarm engaged. Explained role of P.T. in the hospital. Patient agreeable to participating with evaluation. At the conclusion of the evaluation, patient was supine in bed, bed alarm engaged and necessities within reach. Daughter present. RN updated. All lines intact throughout session. Vital signs stable throughout session on room air. **Skin integrity:** Bilateral groin sites appear intact Pt reporting abdominal pressure, similar to when she required catheterization overnight and reports inability to urinate. RN notified. **Functional/Objective measure(s)**	540-544

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Boston AM-PAC, mobility raw score: 6 /24 suggesting a 100% impairment in functional mobility and patient is likely to discharge to a post-acute care setting providing daily therapy. **Johns Hopkins Highest Level of Mobility (JH-HLM) Scale:** 2 (turn self/bed activity) This is a high complexity evaluation as the patient has 3 or more personal factors and/or comorbidities, includes examination of body systems addressing a total of 4 or more elements, and clinical presentation is unstable. **Assessment** Orders received, chart reviewed, and spoke with RN. Patient evaluation of high complexity. Pt is a 82 year old female presented with shortness of breath, congestive heart failure, COPD exacerbation and hypertensive emergency. Pt with sepsis PNA, and pulmonary vascular congestion. Pt s/p left heart catheterization, no evidence of contrast extravasation in the left external iliac or left common femoral artery. Rapid response called post procedure 2/2 pt's report of pain. No hematoma noted; likely patient having pain from distended urinary bladder. PMH includes COPD, Sleep apnea, A-fib, CAD s/p stent placements, prior MI x3, HTN, CVA with residual right sided deficits, glaucoma, pacemaker, Hepatitis C . At PLOF pt requiring assist for all mobility including short distance household ambulation and most ADL's. Pt lives with daughter and has paid caregiver for some hours that daughter is working, but reports that she needs more caregiver hours than she is currently being provided. Limiting factors include significant 10/10 R hemibody pain and R groin site pain. Upon assessment, pt demonstrates impairments in bed mobility, transfers, gait, balance, activity tolerance, and strength. Pt with limited participation in mobility and assessment 2/2 R hemibody pain. Pt reports hypersensitivity R hemibody worse than baseline and does not allow therapist to touch R hemibody. Pt does demonstrate BLE activation thru partial AROM at all joints while semi-reclined in bed, but does not participate in MMT or sensation testing. Pt agreeable to repositioning in bed with total A for partial rolling and scooting up in bed. Pt does agree to progress mobility pending improved pain management. Pt with notable chronic RUE impairments (see OT consult for details). Pt is below PLOF and will continue to benefit from skilled acute PT to address impairments affecting functional mobility. Recommend post-acute setting to address impairments and maximize functional outcomes. The patient is able to tolerate 1-2 hours of therapy per day. The patient is reasonably expected to actively participate in and benefit from this level of therapy. **Historical Rehab Info** **Historic Info (rehab)** **Primary Diagnosis:** PNA **History of Present Illness:** Pt is an 82 year old female presented with shortness of breath, congestive heart failure, COPD exacerbation and hypertensive emergency. Pt with sepsis PNA, and pulmonary vascular congestion. Pt s/p left heart catheterization, no evidence of contrast extravasation in the left external	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		iliac or left common femoral artery. Rapid response called post procedure 2/2 pt's report of pain. No hematoma noted; likely patient having pain from distended urinary bladder. HIV (+) pending confirmation. **Past Medical History - Rehab:** COPD, Sleep apnea, Afib, CAD s/p stent placements, prior MI x3, HTN, CVA with residual right sided deficits, glaucoma, pacemaker, Hepatitis C **Date/Onset of Injury/Limitation:** 12/27/YYYY **Social History (rehab)** **Patient's Responsibilities:** Hobbies **Lives In:** Mobile home **Living Situation:** Lives with family **Home Access:** Trailer with 3 steps to enter with one R sided rail when ascending; pt holds doorknob and daughter assists. Also ramp entry available. Tub-shower with shower chair and grab bar. Step to get in bathroom. **Preferred Language for Healthcare:** English **Additional Social History Info:** Pt reports she has a caregiver but needs more assistance/hours that have not been approved. Daughter assists as well but does work. **PLOF (rehab)** **Assistive Devices Used:** 3-in-1 Commode, Front wheel walker, Hospital bed, Manual wheelchair, Scooter, Shower chair **Hearing-PLOF:** Hard of Hearing **Vision-PLOF:** Other: blind in L eye; low vision in R **Additional PLOF Info (Rehab):** Pt has a FWW but states she cannot use it 2/2 impaired ROM strength/ROM. She has a manual wheelchair, scooter, bedside commode, shower chair and hospital bed. Pt states she needs assistance for transfers and walking as well as ADLs. **Objective Assessments** **Functional Mobility** **Bed Mobility:** Dependent **Bed Mobility Details:** Pt declines attempts to sit EOB 2/2 R hemibody pain; pt is agreeable to repositioning, requiring total A for partial rolling R and L and scooting up in bed for improved sheet positioning; does not tolerate HOB lower than 40 degrees **General Transfer Details:** Deferred as pt declines attempt 2/2 R hemibody pain **Cognition/Vision/Perception** **Cognitive Status:** Able to follow 1-2 step commands **UE Status:** Impaired RUE, RUE Dominant **LE Status:** Impaired RLE **LE Sensory Status Right:** Impaired light touch **Additional Lower Extremity Status Info:** R hemibody chronic hypersensitivity and allodynia, which pt reports is worse than baseline - pt refuses therapist to	

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		touch RLE; pt is able to perform partial AROM with RLE **LE MMT Right** **Right Hip Flexion Strength:** 2- **Right Hip Internal Rotation Strength:** 2- **Right Knee Flexion Strength:** 2- **Right Knee Extension Strength:** 2 **Right Ankle Dorsiflexion Strength:** 2 **Right Great Toe Extension Strength:** 2 **LE MMT Left** **Left Hip Flexion Strength:** 2 **Left Knee Flexion Strength:** 2 **Left Knee Extension Strength:** 2 **Left Ankle Dorsiflexion Strength:** 2+ **Left Ankle Plantar flexion Strength:** 2+ **Left Great Toe Extension Strength:** 2+ **LE MMT** **LE Additional Strength Information:** Pt declines MMT; is able to demonstrate partial AROM BLE in semi-reclined position in bed **Treatment** **PT TX Plan/Goals Est w Patient/Caregiver:** Yes **PT Treatment Frequency: Other:** 2-4 days per week **PT Treatment Duration:** Length of stay **PT Intervention(s):** Balance training, Bed mobility training, Caregiver training, Gait training, Neuromuscular re-education, Pain management, Patient education, Safety education, Stair training, Therapeutic activity, Therapeutic exercise, Transfer training, Wheelchair management training **Plan for Next Session:** Continue to progress mobility per PT POC. **Therapy** **Discharge Recommendations** **PT DC Recommendations:** Therapy discharge recommendations are made by determining the patient's prior level of function, assessing current functional level, and establishing rehab potential. The overall discharge plan may be affected by input from Physicians, Care Coordination, medical condition/status, family support, and insurance benefits., Pt. would benefit from 1-2 hrs multidisciplinary therapy/day upon d/c from acute care setting to assist with returning to prior level of functioning., If the patient is declining/denied post-acute placement, patient would benefit from continued therapy services and supervision; see equipment recommendations for details., Other: If declining recommendation, pt would require 24/7 assist (with increase in caregiver hours), Home Health PT/OT, and Hoyer lift. **Recommended Equipment:** Hoyer Lift **Hoyer Lift Justification:** Mechanical lift if needed to transfer patient to/from	

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<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>chair, wheelchair, commode. Without a lift, the patient would be bedbound
Hoyer Lift Cond Section: Hoyer Lift

Education
PT Education Provided For: Activity precautions, Assistive devices, Functional mobility training, Positioning, Posture, Safety, Symptom management, Therapy plan of care
Individuals Taught by PT: Patient, Child
Teaching Method: Demonstration, Explanation
Response to Teaching: Communicated understanding, Needs reinforcement
Preferences to Learning: Any/all
Readiness to Learn: Accepting
Barriers to Learning: Acuity of Illness

Pain
Pain Intensity: 10
Acceptable Pain Intensity: 4
Pain Scale Used: Numeric Rating Scale
Pain Location: Other: R hemibody, and R groin sit</td><td></td></tr>
<tr><td>01/03/YYYY</td><td>Hospital/ Provider Name</td><td>@ 1050 hours: Nursing Progress Notes:
Pt 's primary cardiology Dr. requested to see pt. Dr. saw pt here a couple days ago. Per Daughter and pt on call Dr. Bellamokanda paged. Dr. return call and states Dr. N__ (Physician name not available in record) rounding on pt today. Daughter notified.

Addendum notes:
01/04/YYYY:
At 1112 hours:
Clarification of prior entry on 01/03/YYYY @ 1055 hours: Pt's primary cardiologist, Dr. Merry, requested by daughter to pt. Daughter stated pt's cardiologist saw the pt in the hospital a couple days ago. Per daughter and pt request, on call Dr. Bellamokanda paged. Dr. Bellamokanda return call and states Dr. Natarajan is rounding on the pt today. Daughter notified.

At 1142 hours:
On 01/03/YYYY @ 1644 hours: Dr. Natarajan no longer on call per answering service. Dr. Nag now covering per answering service and paged. Dr. Nag returned call stating the schedule was messed up and he is not on call. Answering service called and informed. Dr. XXXX on call and paged.</td><td>531</td></tr>
<tr><td>01/03/YYYY</td><td>Hospital/ Provider Name</td><td>@ 1148 hours: Infectious Disease Progress Notes:
Subjective: No fever.

Vitals:
<table>
<tr><th>Time</th><th>Temperature</th><th>HR</th><th>RR</th><th>NIBP</th><th>NIBP mean</th><th>SaO2</th></tr>
<tr><td colspan="7">01/02/YYYY</td></tr>
<tr><td>1200</td><td>-</td><td>-</td><td>-</td><td>99/53</td><td>-</td><td>-</td></tr>
<tr><td>1345</td><td>-</td><td>87</td><td>-</td><td>-</td><td>-</td><td>-</td></tr>
</table></td><td>98-100</td></tr>
</table>

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		(continued vitals table below)	

1400	-	-	39	154/69	-	-
1445	-	-	-	-	101	-
1515	-	-	-	-	-	100
1530	-	-	-	-	-	87
1620	-	60	-	-	-	-
01/03/YYYY						
0800	-	-	16	-	-	-
0827	36.6	-	-	-	-	-
0828	-	61	-	113/54	74	92

Physical examination:
General: No distress
Chest: Respirations non-labored.
Cardiac: S1S2 heard

Assessment/plan:
Leukocytosis: Follow CBC closely

Positive HIV test: Confirmatory test negative.

Others remain same.

DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
01/03/YYYY	Hospital/ Provider Name	**@ 1330 hours: Labs:** **High:** WBC: 15.1, glucose: 133, BUN: 56, BUN/creatinine ratio: 56 **Low:** RBC: 3.41, hemoglobin: 10.2, hematocrit: 31.1, sodium: 134, chloride: 87, EGFR: 56 **Normal:** Platelet: 299	764-766
01/03/YYYY	Hospital/ Provider Name	**@ 1340 hours: Progress Notes:** **Subjective:** Patient underwent left heart cath yesterday with patent stents in the LAD and RCA. Post-procedure, she developed abdominal pain and discomfort at the right femoral access site. She was taken back to the Cath Lab and had a iliofemoral angiography done which did not show any active extravasation. Patient is complaining of severe pain in the abdomen this morning, unable to move. **Review of Systems:** Negative except as above **Objective:** **Vitals:** Temperature: 36.4C, HR: 63, RR: 18, BP: 118/69, SpO2: 93%, oxygen method: Room air **Physical examination:** **General:** Patient appears distress, AOx3 **Lungs:** Distant breath sounds at the bases bilaterally **Heart:** S1-S2 regular, no audible murmurs **Abdomen:** Diffuse tenderness to palpation, feels tense in the lower abdomen. *Otherwise unremarkable.*	95-98

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Assessment/Plan: • Possible retroperitoneal bleed • Heart failure with reduced EF • Systemic hypertension • CAD • PAF • CAS • SSS s/p DPPM • CVA, history • Will order CT abdomen to evaluate for retroperitoneal bleed, stat CBC and BMP • Hold Plavix and Eliquis, continue Coreg 6.25 PO twice daily • Continue Digoxin 125 daily, Hydralazine 25 3 times daily **Orders:** • Abdomen/Pelvis CT with Contrast • BMP • CBC w/o Diff	
01/03/YYYY	Hospital/ Provider Name	**@ 1532 hours: CT of Abdomen and Pelvis with and without contrast:** **Ordering provider:** XXXX, M.D. **Reason For Exam:** Eval for retroperitoneal bleed **Comparison:** No relevant prior **Provided indications:** Eval for retroperitoneal bleed **Findings:** **Lung bases:** Bibasilar emphysema. **Liver:** Normal morphology. No focal lesion. **Biliary:** Vicarious excretion of contrast into the gallbladder. No biliary ductal dilatation. **Pancreas:** No pancreatic ductal dilatation. **Spleen:** Scattered punctate splenic calcifications. **Kidneys:** No nephrolithiasis. No hydroureteronephrosis. **Adrenal glands:** No focal thickening or nodularity. **Aorta/vascular:** Normal caliber abdominal aorta. Severe diffuse calcified atherosclerosis with approximately 50% stenosis of the proximal external iliac artery. **Retroperitoneum:** Large mixed density right retroperitoneal hematoma extending to the right pelvic sidewall/inguinal canal. This collection measures approximately 8.0 x 10.2 x 14.7 cm. Several small foci of contrast blush within the collection noted on arterial phase imaging (502, 81). **Bowel/mesentery:** Moderate hiatal hernia. No bowel obstruction. No bowel wall thickening. Colonic diverticulosis without evidence of diverticulitis. Large rectal stool ball measuring 6.1 x 7.6 cm. Appendix not definitively visualized. **GYN/GU:** No bladder wall thickening or nodularity. **Abdominal wall:** Normal.	760-761

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
		Bones: No acute osseous abnormality. **Conclusion:** Large mixed density right retroperitoneal hematoma extending to the right pelvic sidewall/inguinal canal measuring up to 14.7 cm. Several small foci of contrast blush within the collection noted on arterial phase imaging are compatible with active hemorrhage.	
01/03/YYYY	Hospital/ Provider Name	**@ 1717 hours: Progress Notes:** **Subjective:** Patient seen for follow-up earlier today. Patient reports generalized bodily pain. PT and OT attempted to work with therapy earlier today but could not as patient reported of generalized pain. No chest pain or shortness of breath. No chills. **Review of Systems:** 10 system review negative except as noted above. **Objective:** **Vitals:** Temperature: 36.3C, HR: 73, RR: 18, BP: 118/73, SpO2: 96%, oxygen method: Room air **Physical examination:** **General:** Patient is awake and alert. Did not appear to be in any distress but only partially cooperative **Eyes:** Patient is compliant with the left. **CVS:** Heart sounds 1 and 2 are present. Regular beats **Chest:** Clear to auscultation. **Abdomen:** Exam was incomplete as patient would not allow me to fully examine the groin and the lower abdomen. Full, soft and mildly tender. Bowel sounds present and normal. **Skin:** Unable to examine the groin as patient would not allow **Assessment/Plan:** **Suspected retroperitoneal bleed complicating left heart catheterization:** • Apparently patient had repeat cath yesterday to further evaluate this. Please see notes from the procedure. • There has been approximately hemoglobin drop of about 2 units since yesterday. • Stat CAT scan of the abdomen and pelvic ordered to further evaluate • Type and screen in case patient requires blood transfusion • Repeat hemoglobin and hematocrit q2hrs • Maintenance IV fluids **CAP** • Improved clinically • Off CTX/Azithromycin **Chronic hypertension:** • Hold BP meds	91-95

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		PAF • Rate is controlled. • Plavix and Eliquis on hold because of suspected bleed **Addendum:** I received a call from radiologist around 4:50 PM regarding his findings on patient's CT of the abdomen and pelvis. I checked with patient's nurse. Apparently the phlebotomist had difficulty with blood draws so the repeat H&H was still pending. I called cardiologist to discuss the CT findings. Plan was to monitor H&H closely and transfuse as needed. I also spoke to interventional radiologist. Apparently cardiologist had spoken to him already regarding any possible interventions. His recommendation was to monitor H&H and call him back if there was any further drop. Subsequently I received a call from patient's RN with report of hemoglobin 7.4 g/dL. I instructed her to transfuse 2 units of packed RBC. Arrangements were made to transfer the patient to ICU. I made a follow-up call and was told cardiology was planning to send the patient to the cardiac lab for further interventions to attempt to stop the bleeding. A few minutes later I received a call from the cardiologist to effect that he had spoken to interventional radiologist and that the patient would be going to the IR department for embolization. Patient was to be sent to the ICU after the procedure.	
01/03/YYYY	Hospital/ Provider Name	**@ 1820 hours: Labs:** **Low:** Hemoglobin: 7.4, hematocrit: 23.5	764
01/03/YYYY	Hospital/ Provider Name	**@ 1836 hours: Vascular Surgery Consultation Report:** **Referring Physician:** IM **Reason for Consultation:** C/f bleed s/p angio **Chief Complaint:** Abdominal pain **History of present illness:** This is an 82-year-old female who is hard of hearing with history of COPD, sleep apnea, atrial fibrillation along with coronary artery disease status post angioplasty with history of prior MI x 3 along with hypertension CVA who presents to the emergency room after being brought in by EMS for chest pain and shortness of breath found to have new onset systolic congestive heart failure. Patient was taken for cardiac cath yesterday 01/02/YYYY. Post-operatively she developed intense abdominal pain as well as pain at access site and was taken back to the cath lab and had an iliofemoral angiography completed which did not show any active extravasation. Due to concern for continued abdominal pain in this setting, a CT Abd/Pelvis demonstrating a right retroperitoneal hematoma extending to the right pelvic sidewall and inguinal canal with small areas of blush. Vascular surgery consulted for surgical evaluation. **Review of systems:** *All systems reviewed and are negative.*	6-10

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		Objective: **Vitals:** Temperature: 36.3, HR: 73, RR: 18, BP: 118/73, SpO2: 96%, oxygen method: Room air **Physical examination:** **General:** Resting in bed, NAD **Abdomen:** Soft, nondistended, mild TTP RLQ, non-peritonitic *Otherwise unremarkable.* *Labs and images reviewed.* **Assessment/Plan:** 82F with extensive PMH recently admitted for systolic congestive heart failure s/p LHC and return for iliofemoral angio due to postoperative abdominal/access site pain found to have R retroperitoneal hematoma with blush demonstrated on CT scan. Patient seen and evaluated, currently HDS and mentating appropriately. Imaging and patient discussed with Dr. XXXX with no surgical intervention planned at this time. Recommendation for IR consultation to address blush demonstrated on CT scan. • No acute surgical intervention • Recommend consult to IR for evaluation of blush demonstrated on CT scan • Rest of care per primary team • Vascular to sign off at this time. Please reach out with any further questions or concerns.	
01/03/YYYY	Hospital/ Provider Name	**@ 1942 hours: Physician Notes:** Informed by the nurse with the result of Abd CT ordered earlier today which showed large retroperitoneal bleed with active possibly arterial bleeding. Discussed first with Vasc Surgery and then IR Dr. Cassudo. Since there was a huge Hgb drop to 7 since last night, it was decided to proceed with angiography for possible embolization of the site of bleeding if possible. Discussed with her hospitalist Dr. XXXX. The patient is getting transferred to ICU. Recommended to transfuse PRBC to keep Hgb >8.0. Hold all anticoagulants.	91
01/04/YYYY (Sequenced per content)	Hospital/ Provider Name	**Nursing Progress Notes:** Report received from day nurse, at time pt's most recent H/H resulted, due to decreasing hgb levels provider paged, transfer orders for ICU and blood transfusion placed. Charge RN aware and at bedside, pt transferred to IR prior to ICU for embolization of bleed.	531
01/03/YYYY	Hospital/ Provider Name	**@ 2030 hours: Procedure Report:** **IR Procedural Sedation Note:** **Histories:** The History and Physical has been completed: Date/Time 01/03/YYYY 20:30:00, Within 30 days prior to procedure: There are no changes	29

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<table>
<tr><th>DATE</th><th>FACILITY/ PROVIDER</th><th>MEDICAL EVENTS</th><th>PDF REF</th></tr>
<tr><td></td><td></td><td>Physical Examination
General: Obtunded.

Assessment:
Diagnosis: Congestive heart failure (Discharge, Medical).
American Society of Anesthesiologists (ASA) physical status classification: Class 3.
Other: 82 year old female s/p cardiac catheterization with large retroperitoneal hematoma.

Plan
Plan for Sedation: Sedation Moderate.
Planned/anticipated route of medication Route is intravenous unless otherwise noted.
Informed consent signed by family, and Informed consent signed by the patient/legally authorized representative. The risks, benefits, and alternatives were discussed with the patient/legally authorized representative including but not limited to bleeding, infection, and damage to adjacent structures. Also explained the post-procedural pain is likely to result, and the severity and length of time of the pain is indeterminate. Patient/legally authorized representative verbalized understanding and agreed to the procedure.
Evaluation Patient's airway, heart, lungs, vital organs, EKG (if required) and level of consciousness have been evaluated immediately prior to start of sedation with no change in plan.</td><td></td></tr>
<tr><td>01/03/YYYY</td><td>Hospital/ Provider Name</td><td>Physician Notes:
XXXX, D.O.
At 2040 code blue was page overhead in the IR suite.
MICU team presented at approx 2043 where at that time first round of chest compression was already started by IR team
At my presentation, patient was in a paced rhythm and was apneic requiring to be bagged
Approximately 25 minutes of ACLS was performed in the IR suite. Please refer to code sheet for detailed breakdown.
*Reviewer's Comments: The corresponding code sheet is not available for review.

XXXX, M.D.
@ 2227 hours: Addendum:
I personally conducted this code blue.</td><td>90-91</td></tr>
<tr><td>01/03/YYYY</td><td>Hospital/ Provider Name</td><td>Transfusion Summary:

<table><tr><td>Time</td><td>At 2116 hours</td><td>At 2116 hours</td></tr><tr><td>Product status</td><td>Transfused</td><td>Transfused</td></tr><tr><td>Product number</td><td>W041023183090</td><td>W041023182451</td></tr><tr><td>Product description</td><td>Red Call AS3 LR 500</td><td>Red Call AS3 LR 500</td></tr><tr><td>ABO/Rh Display</td><td>A positive</td><td>A positive</td></tr></table></td><td>771</td></tr>
</table>

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DATE	FACILITY/ PROVIDER	MEDICAL EVENTS	PDF REF
01/03/YYYY	Hospital/ Provider Name	**Procedure Report:** *(Sequenced per events)* **Procedure Description:** Emergent intubation during code blue **Pre-operative and post-operative diagnosis:** Respiratory failure, Airway Protection, hypercapnia, hypoxemia, CNS depression and cardiovascular instability **Medications:** None **Endotracheal Tube Size:** 7.5 **Indication for endotracheal intubation:** Cardiac arrest **Equipment:** Macgrath Blade #3 **Cricoid Pressure:** No **Number of attempts:** 1 ETT location confirmed by ET monitor, auscultation ETT secured at 22cm at lips. **Complications:** None. **Estimated Blood Loss:** None **Prosthetic devices/any implants/grafts/tissues/transplant or devices:** None	28
01/03/YYYY	Hospital/ Provider Name	**Physician Notes:** I received a phone call this evening around 1830-1845 from Dr. XXXX (the on call cardiologist) stating that he had been notified by the nurse the results of the CT showed a large right retroperitoneal hematoma with active extravasation. He and I briefly discussed the case, at which time he had not actually seen the patient, but notified me that the patient was stable per report. At the time of the phone call he notified me that the hgb had only dropped 2 grams. He also informed me that the patient had been receiving Aspirin, Plavix, and Lovenox, all of which he had stopped when he got the initial call. I told him that I would review the case and images and call him back shortly. Upon chart review, it appears that the patient underwent a left heart catheterization by Dr. XXXX at roughly 0902 on 01/02/YYYY with right groin arterial access. She then underwent a repeat pelvic angiogram via the left groin access roughly three hours later for hypotension and suspected hematoma. A CT scan was finally performed at 1522 the following day, almost 24 hours later. A repeat CBC was also ordered 24 hours later showing a 2 gram drop in hgb. The patient was still on anticoagulation. No coags were drawn, no reversal agents were given. The imaging was reviewed showing a very large right retroperitoneal hematoma with what looked like active extravasation near the right flank, although the origin of the active extravasation was difficult to define. After chart and imaging review I phoned Dr. XXXX again and we further discussed the case. At this time the follow up H&H had resulted showing a further drop in hgb to 7.4 (initial was 12.3 on 01/02/YYYY). Again, I was informed that the patient was stable, but given the drop in hgb, the size of the hematoma, and the active extravasation we decided to proceed with pelvic angiogram. The IR team was paged at 1935. The patient was in the room at 2006. Upon my arrival I spoke with the patient's daughter, explained the situation, obtained consent, and answered all of her questions. When I came into the fluoro	89-90

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		suite the patient was on the procedure table already, she was curled on her right side, somewhat combative, and difficult to direct. She was very pale appearing, clearly uncomfortable and in distress. Given that her blood pressure was still low normal at this (see nurse charting for exact values) I gave the OK for a small amount of sedation to make her more comfortable. I believe the IR nurse gave her 0.5 mg of versed and 25 mg of Fent to calm her. She calmed appropriately and we were able to position her on the table. Over the next 20-30 min while we were prepping she was noted to have a very large protrusion on her right abdomen, which was clearly the hematoma. There was marker on her skin from where the nurses had been tracking the size. I evaluated her left arm for radial access because I was hoping to avoid re-accessing her groins as they had both recently been accessed. CT showed severe stenosis of the left common iliac artery, and the right groin was compromised by the large hematoma. Evaluation of the left wrist showed extensive ecchymosis. Both the radial and ulnar arteries were extremely small and difficult to follow given the hematomas and flow was difficult to detect with US. The decision was then made to access the left groin for the pelvic angiogram. While the patient was being prepped for the angiogram the nurse noted that they were having great difficulty with getting a blood pressure reading. The nurses started a Levophed drip and I informed them early to order pRBCs and to get them infusing as fast as possible. They then informed me that the patient only had one small peripheral IV. I decided to place a triple lumen central venous catheter in the right neck so that they could infuse pressors and blood products. At this point is was roughly 2025 and the nurses and techs spent the next 15 minutes or so searching for supplies only to find that many of the necessary equipment was either not stocked, in another room, or no longer in the location it was supposed to be. In the time they spent looking for supplies, the patient stopped breathing and was not arousable. She had a weak pulse but likely only because she had a pace maker. A code was called and CPR was initiated. I believe the code team arrived roughly 5 minutes later. After roughly 45 minutes of running the code, the patient was pronounced dead. The procedure had never even started. Thinking about the case in depth, it is still very unclear to me why a repeat angiogram was performed and not a CT to evaluate for a bleed as CTA is the standard of care, is far more sensitive for active bleeding, and would have allowed visualization of the presence/location of the bleed. I also don't know why the hgb was not trended q4h or q6h at the very least? And finally, why anticoagulation still being given to this patient with a suspected bleed and hypotension? It was almost 34 hours after the initial event that the IR team was finally consulted. I do believe that earlier intervention could have potentially saved her. In the IR department, there were clearly issues with supplies, location, and overall preparedness for such a case. All of which are unacceptable and could have been avoided. The issues in IR will be addressed in a department meeting/debriefing tomorrow. Although unable to alter the care and decision	

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		making on the floor prior to IR team being consulted, we will make the changes and training necessary in the IR department to avoid any further issues in the future. Despite the poor outcome, thank you to the IR staff and the code team for their excellent and expedited care.	
01/03/YYYY	Hospital/ Provider Name	**Respiratory Therapy Assessment & Treatment:** **Treatment Summary** **Treatment Time Out (RT):** At 2110 hours **Airway Management (RT):** Yes **Airway Management** **Airway Mgmt Charges (RT):** CPR **Airway management:** 1 **CPR statistical:** 1 - **Airway Mgmt Procedures (RT):** Code response, CPR **Airway Management Interventions:** Bag/mask, Other: Pt intubated **Post Airway Management Assessment:** Other: Pt expired **Additional Airway Mgmt Info (RT):** Code blue was called, Pt was manually ventilated via ambu bag and mask until intubated with 7.5 ETT at 2050. ETT secured at 21 at the lip, Positive color change noted on CO2 detector and bilateral breath sounds noted. Chest compressions performed throughout entire code. Unfortunately pt expired and time of death was called at 2109 hours.	545
01/03/YYYY	Hospital/ Provider Name	**Critical Event Note:** Pt arrived to IR room 15 at 2006, Pt was restless and c/o severe ABD pain. Daughter and RNs from 6N01 present when Dr. XXXX, Nicholas got consent from daughter to proceed with pelvic angiogram. Upon arrival I inquired about ordered PRBCs and primary RN informed me that it was just ordered and wasn't ready but that she would get the blood and deliver it to IR when it was ready. Not recent coag labs were in the chart. In order to get Pt in proper position 0.5mg Versed and 25mcg Fentanyl given at YYYY. Time out was at 2019. Pt vitals were difficult to monitor, started Levophed at 4 at 2025 per Dr. XXXX for suspected hypotension. Due to supply chain issues not all necessary equipment was in the room and was out of stock in the department so staff was running around to put a central line tray together due to limited IV Access. Once all supplies were gathered, Dr. XXXX started to prep the Right IJ for a central line when it was observed the Pt stopped breathing, CPR was immediately started. I called for a code blue at 2041. The code team arrived around 2046. See code team documentation for details. **Reviewer's Comments: The corresponding code team documentation is not available for review.* Dr. XXXX called time of death at 2109. Pt was taken out of IR Room 15 at aprox. 2120.	533-534

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01/04/YYYY	Hospital/ Provider Name	**Cause of Death Preliminary Notes:** **COD Forwarded to MD:** Yes **COD Preliminary Cause of Death:** Hemorrhage, Pneumonia, bacterial, Respiratory failure	402-403
01/04/YYYY	Hospital/ Provider Name	**Notification of Death:** **Pronounced by:** Dr. XXXX **Date/Time of Death:** 01/03/YYYY at 2109 hours **Name of Attending Notified of Death:** XXXX, M.D. **Date/Time Attending Notified of Death:** MM/DD/YYYY at 2109 hours **Relationship to Deceased: Other:** Grand-daughter **Name of Family Member Notified of Death:** Sandra Dee Gurula **Date/Time Family Notified of Death:** MM/DD/YYYY at 2109 hours **Name of Clergy Notified of Death:** Darrel Crum **Date/Time Clergy Notified of Death:** MM/DD/YYYY at 2109 hours **Contact Information:** No **Potential Medical Examiner Case:** Yes **Autopsy Requested:** Yes **Provider to sign Death Certificate:** XXXX, M.D. **Autopsy Detail:** Requested by family member **Reviewer's Comments: The corresponding autopsy report is not available for review.* **Candidate to Donate per Organ Bank:** No **Date/Time Organ Bank Notified:** 01/04/YYYY at 0007 hours **Organ Bank Member Notified:** Elizabeth **Actual/Susp communicable Dis:** HIV/AIDS **Appropriate Agency Notified:** Facility Infection Control Practitioner **Most Recent Dx-NOD:** Pneumonia **Release of Remains:** Yes **Release of Decedent:** Yes **Medical Examiner** **Name of ME Notified of Death:** Sara **Date/Time ME Notified of Death:** 01/04/YYYY at 0200 hours **Medical Examiner Released Case:** Yes **Comments:** ME Declined	401-402
12/27/YYYY - 01/04/YYYY	Hospital/ Provider Name	**Related records:** Admission record, assessment, input/output record, medication sheets, orders, plan of care, others, consent, case management notes, social work notes, flow sheet, rhythm strips, patient education. ***PDF Ref:*** *64-65, 67-87, 152-400, 404-482, 492, 503-530, 546-547, 552-759* ****Reviewer's Comment:*** *All the significant details are included in the chronology. These records have been reviewed and do not contain any significant information. Hence they are not elaborated.*	

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