

EXAMPLE 1

A CARE PLAN EXAMPLE FOR A PERSON WITH ADVANCED COPD – STARTING WITH H&P AND DISCHARGE SUMMARY FROM RECENT HOSPITALIZATION, THEN RESULTS FROM CARE PLANNING WITH PRIMARY CARE PHYSICIAN AND OTHERS.

H&P

NAME: Mary Smith

MRN: 12345

DICTATION BY: Dr. John Lee

ADMISSION DATE: 11/29/14

CHIEF COMPLAINT: Shortness of breath

HISTORY OF PRESENT ILLNESS: The patient is a very pleasant 67 year old who comes into the hospital after waking up short of breath. She recently visited the emergency department 3 weeks ago and was sent home on azithromycin and a prednisone taper. She says that she was improving and she forgot to take her inhalers daily. She states that she has a chronic cough that goes on and off throughout the day. Her sputum is white. She denies chest pain, fever, chills, or night sweats. She has no lower extremity edema.

REVIEW OF SYSTEMS: As in the HPI; otherwise the full review of systems was reviewed and is negative.

PAST MEDICAL HISTORY: Chronic Obstructive Pulmonary Disorder, hypertension, hyperlipidemia, osteoporosis, and hypothyroidism.

PAST SURGICAL HISTORY: Hip replacement 2005

ALLERGIES: No Known Drug Allergies. No known environmental allergies.

CURRENT MEDICATIONS:

Albuterol inhaler PRN, fluticasone/salmeterol inhaler BID, multivitamin daily, hydrochlorothiazide 25 mg daily, levothyroxine 75 mcg daily, atorvastatin 40 mg daily, tiotropium daily, St John's Wort,

SOCIAL HISTORY: She is widowed and is a retired school teacher. She lives alone but her family visits her often.

FAMILY HISTORY: Father passed away from an MI at age 56.

PHYSICAL EXAMINATION: Temperature is 37 C, heart rate 95, BP 156/92, respiratory rate is 28 breaths per minute, O2 saturation is 93% on 2 L.

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HEENT: Extraocular muscles intact; pupils equal and constricted; ear canals both clear

NECK: Supple

LUNGS: Wheezes and rhonchi are present bilaterally without crackles. Using auxiliary muscles to breathe.

CARDIOVASCULAR: unremarkable

ABDOMEN: soft, positive bowel sounds

EXTREMITIES: No edema

NEUROLOGIC: unremarkable

DIAGNOSTIC DATA:

White blood cell count is 6.7, hemoglobin 14.8, hematocrit 44.5 and platelets 354,000. Sodium is 136, potassium 4.3, chloride 101, bicarb 24, BUN 27, creatinine 1.25, glucose 120, and calcium 8.7. AST is 14, ALT 13, alkaline phosphatase 51 and total bilirubin 1.2. BNP is 58. Troponin is 0.02. Chest x-ray showed changes consistent with COPD. There is a question of pulmonary hypertension. EKG showed sinus rhythm with a rate of 94 without RVH.

IMPRESSION and PLAN:

1. Acute COPD exacerbation due to noncompliance: The patient felt improved so she stopped taking her controller meds. She will be treated with IV steroids, nebulizers, and empiric antibiotics. I will check blood cultures and sputum culture. Continue on O2 and wean as patient improves. Continue on home medications.
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EXAMPLE 1

DISCHARGE SUMMARY

PATIENT INFORMATION

NAME: Mary Smith

MRN:12345

DICTATED BY: Dr. John Lee

ADMISSION DATE: 11/29/14

DISCHARGE DATE: 12/1/14

DISCHARGE DIAGNOSIS: Acute COPD exacerbation

DISPOSITION: Home in stable and improved condition.

FOLLOW UP: I have asked the patient to follow with her PCP within the next week.

HOSPITAL COURSE:

Please refer to the H&P on 11/29/14.

1. COPD exacerbation
 - a. The patient is a very pleasant 67 year old woman with severe COPD. She came in quite short of breath and tachypnic with respiratory distress. She was treated with steroids and nebulizer treatments and improved over her 2 day stay. She narrowly avoided intubation. Today on my exam, she has slightly tight breathing sounds throughout which I think is her baseline. Her lungs sound more open today. She does get somewhat hypoxic with exertion but does not qualify for oxygen at this point. The patient is otherwise stable and I have asked her to follow up with her PCP within the next week. She will be given a short course of prednisone and antibiotics for 5 days. She should have PFTs when stable.
2. Hypertension
 - a. Initially high but stabilized by the time of discharge. BP 138/88
3. Hyperlipidemia
 - a. Stable. Follow up with PCP.
4. Hypothyroidism
 - a. Stable
5. Osteoporosis
 - a. Stable

DISCHARGE MEDICATIONS:

Discharge Medications
Albuterol
Fluticasone/salmeterol
Aspirin 81 mg 1 tab PO daily
Multivitamin 1 tab daily
HCTZ 25 mg 1 tab PO daily

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Levothyroxine 75 mcg 1 tab PO daily
Atorvastatin 40 mg 1 tab PO daily
Tiotropium 1 capsule via handihaler once a day
Prednisone taper
Levofloxacin 750 mg 1 tab PO daily x 5 days

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Care Plan 12 Feb 2015

Mary Smith

Birthdate: 8/15/1947

Address: 123 Anywhere Lane, Our Town, MD 2222x

Participants in care planning: Dr. M. Welby (PCP), Nancy Nurse, RN (Care Coordinator in Dr. Welby's office), Mary Smith, Marianne Smith (daughter-in-law)

Characterizing Mary Smith's situation:

Mary has severe COPD with exercise-induced desaturation and chronic hemoconcentration. She has been intubated once so far but has been hospitalized three times this year for COPD exacerbation, most recently last week. She continues to smoke, though "only 3-4 cigarettes" per day and never when the children are in her house. Her PFTs today showed substantial desaturation with exercise and an FEV1 of only 35% of predicted. She should start on oxygen now. She is prescribed the optimal medications, but it has been difficult to have her understand the importance of taking controller medications on days when she feels better – she believes you take medicines only when you are sick. She will have the same challenge with continual oxygen, or nocturnal (she's still deciding – especially with the ongoing smoking and a gas stove).

She takes care of two of her grandchildren after school and recognizes that she does not have the energy to do more than to have them watch TV. She does not drive and is dependent upon her daughter-in-law to get to the pharmacy or the doctor (or anywhere else). She pays a neighbor to do the heavy housework now (starting in the last two months). She has Social Security income and owns a small home, she has Medicare and a Medigap policy, and her three sons and their families in the area pitch in to help her.

We talked about the course of COPD and she wanted to know whether this would eventually be fatal. On the basis of her PFTs and recent complications, Dr. Welby confirmed her suspicion that this would get worse and probably would be fatal eventually, and most likely within a few years. Stopping smoking, using the medications, and using the oxygen would help. She wanted to be clear that she did not want to be on a ventilator ever again. Dr. Welby discussed the implications with her and they talked about CPR and decided against that also. Her daughter-in-law was not comfortable with these claims. Dr. Welby urged them both to think more about these decisions, but agreed to write out a POLST form with these instructions for now. She named her daughter-in-law as her durable power of attorney for health care.

Marianne Smith was surprised at the seriousness of the illness and said that she and Mary Smith would talk with the rest of the family and try to provide more help for Mary, including trying to support her decisions and reminding her about her medicines.

Thus, the care plan summary at present:

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- Medications as listed at discharge
- Home oxygen – Mary will call tomorrow as to whether she can handle continuous, or will just do nocturnal for now.
- More help with household upkeep
- Advance care plan forgoing intubation, ventilator, and CPR documented in record and POLST
- Phone calls from Nancy as needed to reinforce learning about medications
- Review of plan in one month