Discharge Planning Project

Ashlee Feyes, Student Nurse (SN)

University of South Florida
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In the clinical setting, I was the student nurse for a 71-year-old male who was admitted on 2/12/15 from Brookdale Assisted Living Facility (ALF). This patient came in for complaints of progressive confusion, expressive aphasia, and altered mental status, and was admitted for Transient Ischemic Attack (TIA) rule out, or diagnosis of a Cerebrovascular Accident (CVA). Pertinent Past Medical History includes Hypertension, Chronic Kidney Disease (CKD) (stage three), Diabetes (type II), Chronic Obstructive Pulmonary Disease (COPD), Sleep Apnea, and Peripheral Vascular Disease (PVD). The patient stated he could not remember when he was admitted, but did have preexisting balance issues and has fallen multiple times at his ALF. The patient stated that he remembered being confused at Brookdale, but the next thing the patient remembers is being in a hospital bed and feeling fine. Physician note in emergency department stated the patient was unable to describe his condition but did not have any motor deficits. Upon admission, the patient received a CT of the head, which was negative, and an MRI, which was also negative but showed age-related atrophy and microvascular disease. Abnormal test results included ammonia levels, which were elevated at 74, and could possibly be due to the kidney disease. An EEG was performed on 2/16/15, which showed mild diffuse slowing, such as what is seen with a diffuse case of encephalopathy. On the date of care (2/17/15), the patient was still being evaluated, although the progressive confusion and altered mental status has been resolved. Discharge planning included a referral to Brighton Gardens acute rehab center, and two follow up appointments.

Discharge Diagnosis

According to the patient, he completely understood why he was hospitalized, although he could not fully remember the entire situation. He stated that he remembered being mildly confused, and believes that the staff at Brookdale allowed his confusion to progress for a long time before sending him to the hospital; the patient recalls about seven days between onset and
the admission date. Since this patient was admitted for rule out of TIA versus CVA (Stroke), there are specific core measures and teachings for this disease process. Core measures include Venous Thromboembolism (VTE) prophylaxis, anticoagulation therapy for patients with atrial fibrillation and atrial flutter, thromboembolic therapy, antithrombotic therapy by end of hospital day two, stroke educations, rehabilitations assessment, and discharged on antithrombotic and statin medication (Joint Commission, 2014). All of the pertinent core measures were taken for my patient, such as VTE prophylaxis with Lovenox, antithrombotic therapy with Plavix, stroke education was in place with education handouts and videos through his television, rehabilitation assessment and referral to a rehab center, and the patient was placed on Lipitor prior to discharge. The patient did not receive thromboembolic therapy because the MRI and CT of the head were negative. The patient was given education through his television per his request, and I sat down and went over the education leaflet with him and asked for teach back at the end. The patient correctly explained the causes of a stroke, risk factors, and preventative measures to me within two hours of time.

**Medications**

Within the discharge paperwork, and throughout the plan of care, there has been a reconciled list of the patient’s medications, which includes refills after each medication and new prescriptions at the top of the page, which will also be highlighted for the patient. Due to the patients multiple disease processes, the reconciled list includes about 25 medications total. Each medication states the last dose given in the hospital, and when the next expected dose would be given. Since the reconciled list includes so many medications, I will only discuss the new medication in depth in this essay, although I went over every medication with the patient. Upon discussion, I found out that the patient was a prior employee of the health care system as a
psychiatrist, and had a very thorough understanding of all the medications he was previously
taking. There was only one newly prescribed medication, which was Lipitor. I educated the
patient that Lipitor is used to lower the lipid or fat count in his blood vessels, which is for
primary prevention of a stroke (Vallerand et al., 2015). I instructed the patient that possible
adverse reactions of this drug are rhabdomyolysis (look for any brown colored urine), and
angioneurotic edema (swelling of eyes/mouth/face) (Vallerand et al., 2015). Common side effects
of this drug are rashes, abdominal cramps, constipation, diarrhea, flatus, and heartburn (Vallerand
et al., 2015). The patient showed thorough understanding through teach-back and stated that he
would look out for the adverse reaction signs.

**Home assessment**

The patient lives at a Senior Assisted Living Facility called Brookdale. This is a safe
living condition, in which health care team members can observe the patient. Here the patient
also receives medication dispensed by a nurse, which can prevent overdosing or missing
necessary medications. The patient stated that he knew he needed to move into an ALF when he
began taking multiple medicines, and was unable to walk short distances by himself, since his
wife is unable to take care of him. There are many benefits to living in an ALF, such as not
needing transportation to retrieve his medications, food being provided by the facility, and a
facility van that takes residents to and from their appointments so they do not have to drive.
Financial concerns are minimal, as the patient is covered with Medicare insurance. Medicare
covers the cost of living in the ALF, and follow-up appointments. Potential hazards would be
any stairs, which the patient has identified the facility is only one story and any stairs also have a
set of handicap accessible ramps nearby.
Follow Up

Follow up appointments were not related to the hospitalization diagnosis for this patient. The patient only had two follow up appointments scheduled, which were for his previous past medical history. One appointment is scheduled for one month after discharge at a pulmonologist and sleep study center for his COPD and Sleep Apnea. The other appointment needs to be scheduled within three to five days post discharge, and will be with an endocrinologist for his Diabetes. The patient did not receive a referral to a neurologist, nor to a nephrologist, possibly due to the assumption that he already has his own specialists in these areas. The patient was instructed on when to go to his follow up appointments, and to bring his identification and discharge paperwork if needed. The facility he was being discharged to, Brighton Gardens Acute Rehab, was also instructed on follow up appointment dates. Aside from appointments, the patient was also sent home on oxygen via nasal cannula and CPAP at night, both of which the patient previously had at home. All members of the healthcare must work and prior to discharge PT, OT, and the social worker cleared my patient.

Summary

Important considerations to prevent readmission for my patient specifically include monitoring and managing his Hypertension, PVD, Diabetes, COPD, and sleep apnea, since all of these diseases can contribute to a stroke (high volume blood flow, vessel damage, and lack of oxygen). The patient should also manage the CKD as well as possible to prevent buildup of ammonia in the brain, which can also cause confusion and encephalopathy. The healthcare team at Brighton Gardens must keep a close watch on this patient for any other signs of confusion or unilateral weakness, which can indicate another stroke.
References


http://www.jointcommission.org/assets/1/6/Stroke.pdf

