# Case Study No. 1

## *Quality Improvement Review of Acute Care Transfers*

**Brief Case History**

Mrs. Lauren Hayes is an 89 year-old woman admitted to your facility for post-acute care following a 5-day inpatient admission for pneumonia. She was reported by the hospital discharge planner to be "clinically stable". Her medical diagnoses include:

- CHF
- HTN
- DJD
- Coronary artery disease
- Hypothyroidism

**Hospitalization**

- Required continuous oxygen to maintain pulse ox greater than 93%
- Pneumonia was treated with IV antibiotics - changed to oral antibiotics on the day of transfer
- Treated for CHF with an increase in her usual dose of Furosemide
- BP ranged from 94/60 to 130/60 and her BP meds were held on some days due to hypotension
- Developed severe diarrhea on the day prior to discharge and a stool specimen was sent for C. difficile toxin assay

**Medications at Discharge**

- Levaquin 500 mg daily--first dose to be given on morning of transfer
- Furosemide 40 mg BID (usual dose prior to hospitalization was 40mg daily)
- Atenolol 50 mg BID
- Levothyroxine 125 mcg daily
- Acetominophen 650 mg TID
- Albuterol via nebulizer TID

**Change in Condition**

- The day after admission, the CNA told the nurse that the resident did not want to get out of bed for breakfast and more tired and weak than usual
- The CNA used a Stop and Watch tool to communicate these findings

- The nurse evaluated the resident using the Change in Mental Status Care Path and found:
  - Resident lethargic but could be easily aroused and knew her name/date/location
  - Resident reported 4 episodes of diarrhea overnight , no appetite and feeling too weak to get out of bed
  - VS: Lying down: BP 96/60 Apical HR 100 Sitting up: BP 80/60 Apical HR 120, with dizziness during position change, RR 24, Temp 100 orally
  - Clear lungs sounds, no cough
  - Abdomen had hyperactive bowel sounds and was diffusely tender

**Actions Taken**

- The nurse completed relevant sections of the SBAR and called the NP who said she would be able to see the resident within 2 hours
- The NP ordered:
  - Hold morning medications
  - CBC and basic metabolic panel
  - IV fluid
  - Obtain the results of the stool specimen sent for C. difficile toxin assay

**Outcome**

- The NP arrived 2 hours later and found the resident confused and difficult to arouse
- Vital signs: systolic BP 80 lying flat in bed with resting HR 120, Temp 101.5 po , RR 28, and pulse Ox 86% on 2 L of oxygen by nasal cannula.
- The resident said: “I think I should go back to the hospital...I feel like I am getting sicker by the minute.”
- The family was called and agreed to the transfer
- The nurse completed the Transfer Checklist and relevant sections of the Transfer Form and called the ambulance
- Mrs. Hayes was readmitted to the hospital as an inpatient