



Protecting, Maintaining and Improving the Health of Minnesotans

F309 SCENARIOS

CASE #1

A 68 year old male resident was admitted to the facility on 5/3/08 with diagnoses that included cellulites of the leg, diabetes mellitus, acute renal failure, and congestive heart disease. On 6/2/08 the resident was admitted to the hospital for an elective cholecystomy. The resident developed complications that included diagnoses of C-difficile, MRSA, and e-coli sepsis. The resident returned to the facility on 6/12/08 with new complaints of neck pain, back pain, and upper right extremity pain with numbness of the thumb, index and middle finger.

The resident received Occupational Therapy from 8/11/08 through 8/28/08 for the continued complaints of neck, back and upper extremity discomfort. The OT discharge summary dated 9/5/08 indicated the resident's pain was consistent with a median nerve compression/carpal tunnel type syndrome. The resident also had some swelling of the right wrist, with continued pain in the right arm, neck and back. The resident had received OT three times a week for therapeutic exercise, therapeutic activity, e-stimulus, and ultra sound treatments to the neck, shoulder, elbow and wrist. The discharge summary indicated "Pt has plateau. Still has pain." The OT recommendation on discharge was for the resident to be referred to the Physician's Back and Neck Clinic for an evaluation.

A pain assessment dated 10/14/08 indicated the resident had moderate pain daily of the right wrist, hand, and elbow and back. On readmission to the facility on 6/12/08 the resident received Gabapentin 100 mg TID for pain. On 8/4/08 Oxycodone 5 mg every 4 hours PRN was ordered for pain and on 9/18/08 Oxycodone 5 mg was ordered to be given every morning for pain.

The resident medication administration records identified the resident received PRN Oxycodone daily for complaints of right side neck, shoulder and arm pain.

On 10/14/08 the resident stated he had pain due to a "pinched nerve" in his shoulder. The resident stated he had had a hospital stay that kept him bed ridden, and the pain had started at that time. (The resident's hospital stay was from 6/2/08 – 6/12/08) The resident stated he took pain medications that "helped", but did not relieve the pain. The resident stated the therapist thought he should see a specialist, but did not know when that would be. The resident stated if he stood a lot or moved the right arm a lot he had increased pain.

What documentation would you expect to find in the resident record?

Do you feel the resident was at his highest practicable level of well being?

CASE #2

An 89 year old female resident had diagnoses that included neuropathy, osteoporosis and a history of fractured lumbar vertebrae. The resident had been identified on the quarterly MDS dated 1/27/09 with mild pain less than daily. The resident's current pain medication regimen included Gabapentin 400 mg BID for peripheral neuropathy, and Vicodin 500/5mg daily. The resident also had an order for Vicodin one tablet every four hours PRN pain, and Tylenol per the facility standing orders for pain.

The resident's MAR indicated that for the months of November 2008, December 2008, and January 2009, the resident did not receive any Tylenol. The MAR records indicated the resident had received a PRN dose of Vicodin one time in November, five PRN doses of Vicodin in December, and two PRN doses of Vicodin in January.

On 2/24/08 the resident stated she had pain of her "back and bottom." The TMA administered Tylenol.

On 2/25/09 the resident was observed for morning cares. The resident was noted to have redness of the coccyx area with what appeared to be a dried open area on the top upper right corner of the coccyx. The resident was also noted to "whimper" and stated "oh my back" when staff sat her on the edge of the bed. The nursing assistant verified the resident had more frequent complaints of pain, and that they had reported these episodes to the licensed nursing staff. The nursing assistant also stated she was not aware of the reddened "scabbed" area that was present on the resident's coccyx.

The resident's MAR indicated she had received an increase in PRN doses of Vicodin. The resident had received Vicodin on 2/1/09, 2/6/09, 2/9/09, 2/10/09, 2/11/09, 2/12/09, 2/20/09, and on 2/22/09. The reason for the administration of the Vicodin varied between "back" and or "bottom pain." The MAR also indicated the resident had received Tylenol for complaints of "back and bottom" pain on 2/16/09, 2/18/09, 2/23/09 and 2/24/09.

What documentation would you look for in the resident record?

Do you feel the resident was at her highest practicable level of well being?



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CASE #3

A 58 year old female resident was admitted to the facility on 3/25/09 with diagnoses of a subarachnoid hemorrhage following a fall on 3/19/09 and hitting her head. Other diagnoses included a right clavicle fracture, chronic headaches, lupus, acute chronic pain, depression, anxiety and malnutrition. The resident discharge plan was to return to independent living with her spouse.

The resident's hospital admission history and physical dated 3/20/09 identified the resident with a complex past medical history which included chronic pain. On 4/2/09, the physician progress note again identified the resident with chronic pain, and Lyrica was added to the resident's pain medication regimen.

The admission minimum data set (MDS) dated 4/7/09, identified the resident with independent cognitive skills, and with moderate pain symptoms daily. The facility Pain Data Collection and Assessment form dated 3/25/09 indicated the information was obtained from resident interview. The assessment identified the residents description of pain was aching, burning and numbness of the back, joints, right clavicle and right side of her head. The resident rated her pain a 4 on a scale of 1- 5, and indicated she has had the pain for many years. The assessment indicated the resident had relief of the pain with Oxycodone and OxyContin.

The resident current pain regimen included OxyContin CR 10 mg q 12 hours, Celebrex 200 mg qd, Lyrica 100 mg TID, Tylenol ES 500-1000 mg q 6 hours PRN for pain or fever, Oxycodone 5 - 10 mg q 4 hours PRN for pain, Ultram (non narcotic analgesic) 50 mg q 6 hours PRN for pain, and Vistaril 50 mg q 6 hours PRN for pain.

The resident also had an order for Ativan .5 mg q 6 hours PRN for anxiety.

Other scheduled medications included Trazodone 100 mg at HS, Cymbalta 60 mg q am, Prozac 80 mg q am, Lamictal 200 mg BID, and Mirapex 0.125 mg at HS for restless legs.

The resident was observed to be sleeping in her wheelchair on several occasions throughout the days of April 13, 14, and 15, 2009. The resident stated she had no energy and refused therapy due to "too tired."

On review of the resident's March medication administration record (MAR), it was noted in addition to the routinely scheduled pain medications of the OxyContin CR, Celebrex, and the Lyrica, the resident had also received 1 additional dose of Ultram, 6 additional doses of Oxycodone, and 5 doses of the PRN Ativan. On 3/31/09 the resident was given a PRN dose of the Vicodin. The MAR indicated the "resident requested" the medications, and on three occasions "some relief" was documented as the result of the PRN medications.

The integrated nurse's notes on 3/26/09 indicated the resident requested pain medication at 7:30 PM, even though the resident had received Ultram at 5:00 PM. The resident was administered Oxycodone 5 mg and Ativan with no documentation of present symptoms. At 9:45 PM, the resident had a fall out of the wheelchair, the resident stated "I fell asleep, and slid out of the chair."

The April MAR indicated that from April 1st to April 14th, the resident had received daily PRN medications including 9 PRN doses of Ativan, 11 PRN doses of Oxycodone, 4 PRN doses of Ultram, 1 PRN dose of Tylenol, and 3 PRN doses of Vistaril. On 4/8/09 along with the regular scheduled medications, the resident received Oxycodone 10 mg at midnight, and 5 mg at 10:25 AM, Ultram 50 mg at 5:00 PM, and Tylenol ES at 7:30 PM. The integrated nurse's notes also indicated the resident's blood pressure medication was held due to a low reading and that at 4:30 PM, the resident was easily falling asleep "fell asleep during B/P check." At 7:00 PM the integrated nurse's note indicated the resident complained of pain. At Midnight on 4/9/09 the resident was found on the floor in her room. The possible cause of the fall was identified as "tired and unsteady". The resident was administered another dose of Oxycodone 10 mg for "resident request for pain."

Because the resident was identified as short term rehab, what information would you look for in the resident record?

Do you feel the resident had managed pain control? If not, what action would you take?

What monitoring, if any would you look for in the resident record? Or is monitoring even necessary due to the potential short term stay?

Do you feel the resident was at her highest practicable well being?