Barney Smith 3
Transition of Care
Interprofessional Hospital Discharge to Home

Description:
This transitions of care Interprofessional education standardized patient serves to train
Year 3 medical students and graduate students from physical, occupational and speech
therapy in the transition of care of a frail older adult from the hospital to home. It is the
third of a six part progressive standardized patient encounter on palliative care. This
clinical simulation is an encounter with Barney as a hospitalized patient with newly
acquired functional decline. Out learners pain experience in the interprofessional team
assessment of a hospitalized older adult's functional status and the team management
of that patient's transition of care from the hospital to home. Educational modalities
include web-based instruction, the simulation, and a small group discussion of the
interprofessional set of leaners immediately following the encounter facilitated by
interprofessional faculty.

Educational objectives:

1) Perform an interprofessional, comprehensive team assessment of a
hospitalized older adult's functional assessment and the team management of that
patient's transition of care from the hospital to home.

2) Understand the role that individual disciplines play in conducting a comprehensive
assessment of an older adult's functional status

3) Assess specific risks and barriers to older adult safety as they transition from the
hospital to home

4) Assist family caregivers in identifying care-giver responsibilities and
potential care-giver burden
Barney Smith 3
Transition of Care

Story Line
Barney Smith, age 65, has been undergoing treatment for multiple myeloma for the past 5 years. During this time, he has been getting progressively weaker with each round of chemotherapy, but he continues to be encouraged by his hematologist/oncologist that the medication may maintain the stability of his cancer. He was admitted to the hospital 4 days ago with pneumonia and is receiving IV fluids and IV antibiotics. He initially required 4L of oxygen, but he is now down to 2L per nasal canula. His vital signs are stable. The team is ready to discharge him home.

Learner Tasks
Work within an interdisciplinary team of learners to:
1. Identify his discharge needs, including medications, equipment, home health, community supports, family/caregiver support, follow-up
   a. This will involve both chart review and patient/family interview
2. Communicate your findings to the patient and family.

There is no designated leader of this team although we expect one to emerge depending on which types of learners are involved in each scenario. In all encounters, there will be at least one non-medical student to be a part of the inter-professional team. When other members of the team are not present, the medical student is responsible for covering that portion of the encounter (i.e. gathering information about dysphagia even if speech and language pathology students are not present).

Schedule
15 min – chart review with interprofessional team
25 min – encounter with standardized patient
10 min – team discussion about final recommendations
20 min – debriefing session with both teams and faculty

Working as an interdisciplinary team (TeamSTEPPS)
1. Team Structure – identify each team member and how his/her specialty will fit into his/her role on the team. Divide roles and responsibilities related to information gathering, both by interview and by physical exam. Determine who will be in charge of information consolidation and delivery at the end of the assessment. This will be the team leader.
2. Leadership – identify who the leader will be. This person will introduce everyone to the patient and wife and will be responsible for information delivery at the end of the assessment. He/she should not identify who the leader is to the patient and wife, but it will likely be apparent.
3. Situation Monitoring – each team member is expected to gather information from his/her colleagues, even from different specialties. You may be surprised to find that many specialties gather similar information in different ways. Team members should be aware of each other, the patient/family, and themselves to work together as a team.
4. Mutual Support – team members are equals regardless of specialty and must treat each other as such. You are expected to anticipate and support other team member’s needs, which may include things like helping move the patient or gathering information someone may have missed.
5. **Communication** – team members must communicate before and after the encounter outside the room. In addition, it appropriate to exchange information within the room in a respectful manner.

**Pharmacy Assignment (Medical Students ONLY)**

1. You will receive an email from a Pharmacy students in Lawrence detailing some issues with the medical reconciliation that he/she is completing at Wal-Rite (the community pharmacy the patient uses to fill his prescriptions). The patient is presenting to the pharmacy the day following discharge from the hospital to fill all of his outpatient medications, including the new scripts from the hospital.

2. You are required to communicate with the Pharmacy students via email between 4/13 and 4/18. **YOU MUST CHECK YOUR EMAIL DAILY DURING THIS TIME.**

3. After collaboration, the Pharmacy students will type out final recommendations and he/she will forward the entirety of your email communication to faculty. **PLEASE NOTE – WE WILL EVALUATE YOUR PARTICIPATION BASED ON THIS EMAIL.**

**Script**

Set-up: Barney is lying in a hospital bed in a gown. His wife is sitting at bedside. Barney has been a little confused and weaker than normal in the hospital. He is able to follow all commands, but he lacks orientation to year and is confused about the details of his hospital stay. His answers to questions are frequently corrected by his wife who is more accurate in her account. It is important for BOTH Mr. and Mrs. Smith to be engaged in answering the medical team’s questions.

The team enters the room together.

Learners: Knock on door. Enter room. Introduce themselves and their role. *Hi, I’m _____, with Geriatrics. Hi, I’m ___, with Physical Therapy. Etc*

The learners will hopefully address Mr. Smith first and interact with both SPs. It is important for both to participate equally. The information provided by Mrs. Smith will be accurate and information from Mr. Smith may not be.

Barney: I’m doing great. I am ready to go home. I walked the halls last night and ate all of my breakfast.

Wife: He’s doing well. Last night was a better night. He got up to the commode with my help and he otherwise slept all night I was just told by the nurse that we might be discharged today. Is that true?

Learner: That is exactly why we are here. We would like to review a few things to make sure you have all of the tools you need to return home safely.

In any order, the team of learners should now go through the following:

**Medication List**

The medical student should review Barney’s home medication list with Barney and his wife and cross check things that may be different now. (In Barney 2, he is not on any medications. On
admission to the hospital he is on a few medications, but several new ones will be added now.) They will need to stop some things that have been started in the hospital and change doses on other things.

**Home List:**
- Synthroid 75mcg po qday
- Esomeprazole 40mg po qday
- Carvedilol 6.25mg po bid
- Oxycodone/APAP 5/325 1 po q4h prn pain

**New List:**
- Azithromycin 500mg 1 po qday
- Protonix 40mg 1 po qday
- Carvedilol 12.5mg 1 po bid
- Sennosides/Docusate 1 po bid
- Multivitamin 1 po qday
- Oxycodone/APAP 5/325 1 po q4h prn pain
- Synthroid 75mcg 1 po qday

**Functional Status**
The student may ask questions about Barney’s independence at home before the hospital stay and how he is doing now. Much of this information will be available in the chart. These questions can be answered by either Barney or his wife, but both of them need to be engaged. Barney should underestimate how he was doing at home and overestimate how he is doing now.

Prior to admission:
- Independent in all activities that he had always done. His wife does the cooking and laundry. Did the grocery shopping with a list from his wife. Independent in self-care.
- He is a retired residential architect. Prior to hospitalization, his days were mainly spent at home. He was very active in his church group and had weekly outings with friends.

At discharge:
- Dressing - needs assistance, isn’t picking out clothes that match
- Feeding – independent although requires some coaxing.
- Walking – has a need for a walker at home. Used one in the hospital with ambulation. Has not worked on steps yet. Has minimal fatigue when walking short distances (i.e. to the bathroom) and significant fatigue with longer distances.
- Toileting – using commode.
- Bathing – needs assistance.
- Shopping - likely unable to walk the store.
- Housework – never did
- Finances- Ann has always done the finances
- Cooking – never did
- Driving – too weak at this point and judgment is questionable. Wife normally drives but doesn’t want to leave him home alone. Will need help to either stay with him at home or go shopping for him.

**Living Situation**
Lives in a one story home with two steps to get inside. No grab bars, etc. in the home.

**Home support**
Wife is home all the time.
Tom is the only child that lives in town and he is available on Saturdays
Many friends from church. Good support.

**Exam**
Vital Signs provided in chart before entering room
Learner team to complete exams of at least neuro, strength, and gait. All exams should be normal except for his confusion and mild weakness of his proximal (hip) muscles.

**Physical:** Barney is able to move his extremities without difficulty. His deficit is only when he tries to stand from a sitting position and when he walks (both due to mild proximal muscle weakness). If the SP is asked to stand up, he should use his arms to help him stand. Take small slow steps and when turning, turn with multiple steps. Do not swing arms while walking. His wife should feel uncomfortable with how he is walking and should try to be a stand-by assistant if a student isn’t there (or suggest that they help him).

**Mental:** Barney seems intact cognitively except that he answers some questions about his hospitalization and his daily activities incorrectly. He should underestimate what he was doing before hospitalization and overestimate how he is doing now. For example, he will think that he has been driving (when his wife has) and that he walked the halls without issue last night, but wife will correct both of those answers.

**Follow Up Plan**
The learners should set you up with home health for therapy, a bath aid, a home assessment or recommend grab bars and picking up rugs off the floor, social services such as meals on wheels, possible care attendant, and/or respite for wife, consider finances and what supports may be affordable, follow up with your hematologist.
Barney Smith
Medical Record Number 872-04947

Admission History and Physical
CC: “I can’t breathe”

HPI: Mr. Smith is a 65 y/o M who presents to the Emergency Department with shortness of breath. It began 2 days ago and has gotten progressively worse. He reports productive cough with green sputum. He denies wheezing. He complains of subjective fevers and chills, but was unable to find a thermometer at home. He denies chest pain. He also complains of progressive weakness that was made worse since his shortness of breath began. He felt like this when he had pneumonia in the past.

PMH:
Multiple Myeloma, currently receiving chemotherapy, last dose was one month ago
Hypertension
Normal colonoscopy at 55

FH:
Father died age 69 from colon cancer
Mother died last year, age 88, unknown cause
3 sons are healthy

SH:
No history of tobacco
Drinks 2 glasses of wine 2-3 times per week
3 sons. 2 live in St. Louis. One (Tom) lives in KC
Married 44y. Wife named Ann.
Retired residential architect, owns his firm.
Goes to church weekly. Believes in the power of prayer.
Large church family with lots of support available and engaged.
Independent in ADLs and IADLs

Allergies: NKDA

Home Medications:
Synthroid 75mcg po qday
Esomeprazole 40mg po qday
Carvedilol 6.25mg po bid
Oxycodone/APAP 5/325 1 po q4h prn

ROS:
General – weight loss 10# in 6 months, generalized weakness
HEENT – no change vision/hearing, no problems swallowing
CV – no chest pain or palpitations, no edema
Chest – shortness of breath, cough
Abd – constipation, no pain
Ext – lower extremity weakness, poor balance
 Neuro – no memory loss
Psych – denies depression and anxiety
Skin – denies wounds and rashes
Heme – no bleeding or bruising

**Physical Exam:**
Vitals – Temp 101.2
BP 110/70
Pulse 112
Resp 24
SaO2 82% on Room Air, 94% on 4L per nasal canula
General – frail appearing, increased work of breathing
HEENT – moist mucus membranes, conjunctiva clear, neck supple and without lymphadenopathy
Chest – using accessory muscles, poor air movement, diminished sounds diffusely, scattered wheezes, rales right lower lobe
Chest – tachycardia, regular rhythm, no murmur, no edema, no carotid bruits
Abdomen – soft, non-tender, non-distended, bowel sounds normoactive, no masses, no hepatosplenomegaly
Extremities – moving all extremities with normal range of motion, no change in sensation, equal strength bilaterally
Neuro – mildly confused, alert, oriented to person, place, and time

**Labs:**
CBC
Hemoglobin 12.5
White Blood Cell 12.3H
Platelet Count 234

CMP
Normal

UA negative

Chest X Ray : right lower lobe infiltrate

**Assessment**
1. Pneumonia
2. Mental Status Changes
3. Hypertension
4. Constipation

**Plan**
1. Start IV antibiotics.
2. Start IV fluids.
3. Start nebulizer breathing treatments.
4. Monitor blood pressure closely.
5. Start sennosides/docusate
6. Pantoprazole for GI ulcer prophylaxis
7. Lovenox for DVT prophylaxis

Barney Smith, Medical Record Number 872-04947
Progress Note Day 2

S: Patient confused and unable to provide history this am. Per nursing, began to get confused last night after wife went home. He was having non-frightening hallucinations and calling out for his wife. He tried to call her several times through the night. He denies shortness of breath. Nods yes for pain but is unable to state where pain is.

Meds:
Carvedilol 6.25mg po bid
Normal Saline IV 100ml/hour
Ceftriaxone 1gm IV q24hours
Azithromycin 500mg po qday
Albuterol/Ipratropium inh soln q4hours
Pantoprazole 40mg po qday
Lovenox 40mg sq qday
Fentanyl 25mcg IV q3hours prn pain
Sennosides/Docusate 1 tab po bid
Multivitamin 1 po qday
Oxycodone/APAP 5/325 1 po q4h prn
Synthroid 75mcg po qday

O: T 100.1 R 18 P 98 BP 156/89 SaO2 99% on 2L per NC
General – calm, without distress, lying in bed, picking at his IV dressing
HEENT – moist mucus membranes, nasal canula in place
CV – regular rate and rhythm, no murmurs
Chest – rales right lower lobe, no wheeze
Abdomen – soft, nontender, bowel sounds +
GU – foley draining clear urine
Extremities – SCDs in place, no edema
Neuro – arousable, oriented to person, mumbling

Labs:
Hemoglobin 12.4
White Blood Cell 10 H
Platelet Count 198

CMP -Normal

Assessment:
1. Community Acquired Pneumonia
2. Delirium
3. Dysphagia
4. Hypertension
5. Discharge Planning

Plan
1. Continue IV antibiotics and IV fluids. Titrate down on O2.
2. Monitor closely. Remove lines as able. Consider d/c foley, SCDs.
3. On restricted diet
4. Increase coreg.
5. Frail older adult with chronic disease. May need services at home. PT, OT, SLP consult.

Barney Smith, Medical Record Number 872-04947
Progress Note Day 3
S: Patient less confused today. Per nursing, has been making more sense although somewhat tangential in thinking. Denies shortness of breath. Cough improved. Wife at bedside. Both patient and wife want to d/c home today.

Meds:
Carvedilol 12.5mg po bid
Normal Saline IV 100ml/hour
Ceftriaxone 1gm IV q24hours
Azithromycin 500mg po qday
Albuterol/Ipratropium inh soln q4hours
Pantoprazole 40mg po qday
Lovenox 40mg sq qday
Fentanyl 25mcg IV q3hours prn pain
Sennosides/Docusate 1 tab po bid
Multivitamin 1 po qday
Oxycodone/APAP 5/325 1 po q4h prn
Synthroid 75mcg 1 po qday

O: T 98.4     R 16     P 84     BP 144/88     SaO2 92% on room air
General – calm, without distress, lying in bed, intermittently engaged in conversation
HEENT – moist mucus membranes
CV – regular rate and rhythm, no murmurs
Chest – clear to auscultation, no wheeze
Abdomen – soft, nontender, bowel sounds +
GU – no foley
Extremities – TED hose, no edema
Neuro – arousable, more alert, oriented to person, year

Labs:
CBC
Hemoglobin 12.5
White Blood Cell 9.3
Platelet Count 204

CMP
Normal

Assessment:
1. Community Acquired Pneumonia
2. Delirium
3. Hypertension
4. Discharge Planning

Plan
1. D/c IV fluids. Change to oral azithromycin to finish 5 day course. d/c ceftriaxone after today’s dose.
3. Increase carvedilol to 12.5mg po bid
4. Interdisciplinary meeting this afternoon to discuss services for home.
Barney Smith, Medical Record Number 872-04947
Speech and Language Pathology

Motor speech: Mr. Smith is experiencing mildly reduced respiratory support for speech. His voice is mildly decreased in loudness. Articulation and resonance are unremarkable.

Expressive language: Mr. Smith speaks in complete, grammatically correct sentences. The information he conveys is mostly accurate, but he does sometimes report information that is not true. He can write his name and a sentence about himself.

Receptive language: Mr. Smith is able to follow two-step directions and the gist of a conversation. He can comprehend written sentences.

Cognition: Mr. Smith scored 25/30 on the MoCA; this score is one point below the cutoff for non-impaired adults. He lost 3 points on the Serial 7s section (0/5 correct subtractions), 1 point on the Delayed Recall section, and 1 point on the Orientation section (orientation to place).

Swallowing: Mr. Smith does not exhibit any swallowing difficulties; however, he reports that he has lost about 10 pounds over the last 6 months.

Hearing: Hearing is within functional limits.
Barney Smith, Medical Record Number 872-04947  
Physical Therapy Note

S: Mr. Smith is alert and oriented x 3. He reports “feeling better” and “wanting to go home”. When asked how much he has been out of bed over the previous 24 hours, the patient reported that he has been “walking around the hallways just fine”. However, the patient’s wife expressed concern with his answers and said that he is “weak” and “has needed help with walking and using the bathroom”.

O: Bed mobility and Transfers: Independent with bed mobility; Min assist with sit to stand.  
Gait: Patient ambulated 20 feet with min. assist (holding onto IV pole) on 2L oxygen; Oxygen saturation during ambulation = 94%; Shuffling and slow gait; Loss of balance x 1 but recovered independently; Timed Up and Go = 16 seconds, needed to push off arms of chair to stand and demonstrated significant fatigue after test.  
Strength: Bilateral Hip Flexion 4-/5; Hip Extension 4-/5; Knee Flexion 4/5; Knee Extension 4/5; Ankle Dorsiflexion 4+/5; Ankle Plantarflexion 4/5.

A: Mr. Smith participated in his physical therapy with a positive attitude. He demonstrates improved ambulation tolerance on 2L of oxygen compared to yesterday; however, his safety awareness continues to be poor. He also fatigues rather easily and currently needs supervision during ambulation and may benefit from an assistive device.

P: Progress ambulation activities. Educate patient and wife on discharge plan.
Barney Smith, Medical Record Number 872-04947

Occupational Therapy Note

Occupational Therapy Profile:
Mr. Smith is a 65 year-old Caucasian male who lives in Kansas City with his wife. Mr. Smith is a retired architect and built his own home. He lives in a single story home with two steps to enter the front door. His wife is primarily at home throughout the day and completes all cooking tasks, laundry, and the housework. Prior to hospital admittance, Mr. Smith drove to the grocery store and to places in the community. Mr. Smith and his wife are actively involved in their church community and enjoy spending time with their friends as well as cheering on the KU Jayhawks. He has one son who lives in town and comes over to his home on most Saturdays.

S: “I just want to go home.”

O: Mr. Smith was seen for occupational therapy services on this date with wife present. Mr. Smith was supine in bed upon arrival, 2 L. nasal cannula in place. Mr. Smith demonstrated independent bed mobility. Mr. Smith was alert and oriented to person and place. Mr. Smith demonstrated a sit to stand transfer with standby assist. Mr. Smith ambulated 15 feet to restroom with IV pole with standby assist and verbal cues. Mr. Smith completed grooming routine while standing at the sink with standby assist x4 minutes. Mr. Smith demonstrated toilet transfer with use of grab bars and standby assist. Mr. Smith ambulated 15 feet to return to bed with verbal cues and standby assist. With Mr. Smith demonstrated stand to sit transfer into bed holding on to IV pole. He was cued to reach for bed instead of holding pole. Mr. Smith returned to supine position independently. Nasal cannula in place at 2 liters.

A: Mr. Smith is motivated to go home and demonstrated his ability to complete basic ADLs. However, he tires easily and wanted to get back in bed once his grooming was complete. He is unsteady when walking and uses the IV pole for support. Corrects positioning with verbal cues. His wife is in the home with him and could provide verbal cuing and standby assistance once trained to assist. Mr. Smith may require additional therapy services post discharge from inpatient to address driving, and home safety when bathing and toileting. Additionally, his wife may need respite care from supervising him in order to perform IADLs for them both. They have a son who can provide support on Saturdays.

P: Prepare for discharge planning to home with team. Practice car transfer. Discuss home environment and possible home modifications/assistive devices. Consider caregiver needs. Discuss fall prevention. Provide patient and caregiver education/training.
Discharge Medications

Azithromycin 500mg 1 po qday
Protonix 40mg 1 po qday
Carvedilol 12.5mg 1 po bid
Sennosides/Docusate 1 po bid
Multivitamin 1 po qday
Oxycodone/APAP 5/325 1 po q4h prn pain
Synthroid 75mcg 1 po qday