The following case demonstrates how an interprofessional care plan may be used to formulate a collaborative plan of care for a complex patient/client.

Complex Case: Mr. Jim Rich

Mr. Jim Rich is a 74-year-old man who was recently admitted to the nursing home following an above the knee amputation of his right leg. After drinking one night, he sustained a fall and fractured his right ankle. He did not seek help for several days, as he did not recognize the severity of the injury. He was admitted to the hospital for the consequences of that delay, a gangrenous right foot. At the time of the hospital admission, he was noted to be disheveled and poorly nourished. A psychiatric consult was obtained and it was felt that he was severely depressed. During the hospital stay, he was started on antidepressants. He was discharged to the nursing home on the antidepressant medication and has a scheduled follow-up visit with the psychiatrist. He understands that placement in the nursing home is necessary for rehabilitation and that he will eventually get a prosthesis so that he will be able to walk again.

Past Medical History:

- Hypertension
- Pack year history of smoking
- History of myocardial infarction 8 years ago (after which he quit smoking)
- Alcoholism for which he has been treated 2 -3 times

Allergies:

- No known allergies

Medications:

- Sertraline 50 mg qd
- Amlodipine 5 mg qd
- Tylenol #3 1 tab q 6 hr as needed pain

Social History:

Mr. Rich is a retired banker who was living alone in an apartment. Although well educated, he has had a long history of alcoholism and had gone through treatment “two or three times” with his wife while she was living. Since her death one year ago, he had become more isolated, drinking heavily alone in his apartment. He has about $3,000 dollars in a savings account that he hopes will cover his funeral expenses. He lives on his Canada Pension Plan and Old Age Security and a small pension. Mr. Rich has had to borrow money from his daughter at times in order to make ends meet. He has a son and daughter who live in town with children of their own. At one point in his life, Mr. Rich was active in his community. For a time, he served on the school board. He likes to read and used to keep up with the local hockey teams.

Review of Symptoms

- Stump pain
- Poor circulation in left leg

- Constipation
- Depression
- ETOH abuse
- Hard of Hearing (HOH)

Activities of Daily Living (ADLs)
- Able to feed, dress, and bathe self
- Assistance to toilet x 1
- Assistance to wheelchair x 1

Instrumental Activities of Daily Living (IADLS)
Although able, exhibits signs of lack of interest in many activities.

Advanced Directives
Has no living will.

Environment
Lives in nursing home for rehabilitation. Previously lived alone in an apartment.

Physical Exam:
Weight: 200 lbs. Height: 6'2" BP: 146/90 P: 80

On exam, Mr. Rich is alert, oriented, and pleasant, although responses are limited to few words and he seems to avoid direct eye contact. His only complaint is occasional pain in the amputated leg at night and constipation. His vision was excellent with corrective lenses; he could easily read newsprint. His hearing seemed moderate-severely impaired on gross exam.

Chest was clear. Cardiovascular exam revealed a regular heart rate, no murmur or gallop.

Abdominal exam revealed bowel sounds through-out, no palpable masses, although he was noted to have a large amount of hard stool in his rectum. Examination of his left lower extremity reveals normal proximal pulses but diminished distal pulses. There is an absence of toe hair on the foot and a mild rubor when the foot is dangling. The right stump is wrapped with a compression bandage, shows a well approximated, healing incision, and some mild edema.

The skin over the lower portion of the sacrum is noted to be red and non-blanching. MMSE: 27/30; Mr. Rich had to be prodded for answers, but usually responded correctly.

It is now team rounds and time to develop a problem list and plan of care for Mr. Rich.

This case illustrates the need for a team approach.

1. What is the overarching goal?
Return to independent living in the community with no alcohol dependency.

2. Patient's problems: See Plan of Care Attachment.

3. What is the impact of each problem on the patient's health and quality of life?
Key is to focus on ETOH/depression as overriding problem and the effects that this has on quality of life for elders. Impact is physical, psychological, social, spiritual.

4. What strengths and resources does the patient have for addressing each problem?
Patient's education, intelligence, physical strength, family support system.

5. What additional information is needed?
- GDS
- Assessment by PT/OT for ambulation and of home environment
- Pharmacy consult
- Coordination meeting with psychiatrist
- Social worker to assess eligibility for income support or other support programs, family
- Nutrition consult

6. Plan of care: See Plan of Care Attachment.

7. Expected outcomes: Included in the Plan of Care Attachment.

PLAN OF CARE ATTACHMENT -- Complex Case: Mr. Jim Rich

Problems	Plan	Outcome
Healing of stump	• Observe for signs of infection	• healed -- no infection
Stump pain	• Change to Tylenol; consider low dose of Nortriptyline • Position carefully • Assess phantom pain	• managed, eliminated if possible
Ambulation	• Assess strength, gait • Fit for prosthesis • PT/OT	• (strength) up ad lib • (prosthesis) without assistance
Depression	• Assess; meds and state (GDS) • Psychotherapy • Involve in nursing home activities • Continue Zoloft (Sertraline)	• decreased GDS score • increased socialization and activity attendance • improved appearance and attention to ADLs
ETOH abuse	• Referral to AA volunteer • Assess family situation • Coordinate with psychiatrist	• decrease ETOH intake
Constipation	• Eliminate codeine; • add Sorbitol 70%, 15-300 cc by mouth or orally as needed • Increase fluids, fiber in diet • Increase activities	• no bowel problems
Stage I Decubitus	• Skin care • Positioning • Ambulate/ up in chair	• eliminate

Peripheral vascular disease	• Monitor for complications • Assess nutrition	• no peripheral ulcers
HTN	• Assess BP control	• BP in range < 150/90
CAD	• Monitor • ASA x1 qd • Assess cholesterol levels	• no increase/worsening
Hearing impairment	• Hearing aid	• improved hearing
Decreased financial status	• Assess for income assistance eligibility or other program support • Assist with application process • Meet with family	• manage independently at home
Housing	• Discharge planning by social worker with client and family	• manage independently at home or in assisted living
Safety	• Assess home environment • Stabilize ETOH problem • Assess medications, orthostatic hypotension	• safe at home alone or in assisted living