

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

Case No. 2013-CP-42-2404
Appellate Case No. 2015-001828

RECEIVED

APR 11 2016

SC Court of Appeals

Lisa McKaughan, Individually
and as Personal Representative
of the Estate of William Farr,

.....

Appellant

v.

Upstate Lung and Critical Care
Specialists, P.C. and Sau-Yin
Wan, M.D.

.....

Respondents.

RECORD ON APPEAL (VOLUME 5)

Ashby W. Davis
David L. Williford
Davis, Snyder & Williford, P.A.
5 Hawthorne Park Court
Greenville, SC 29615
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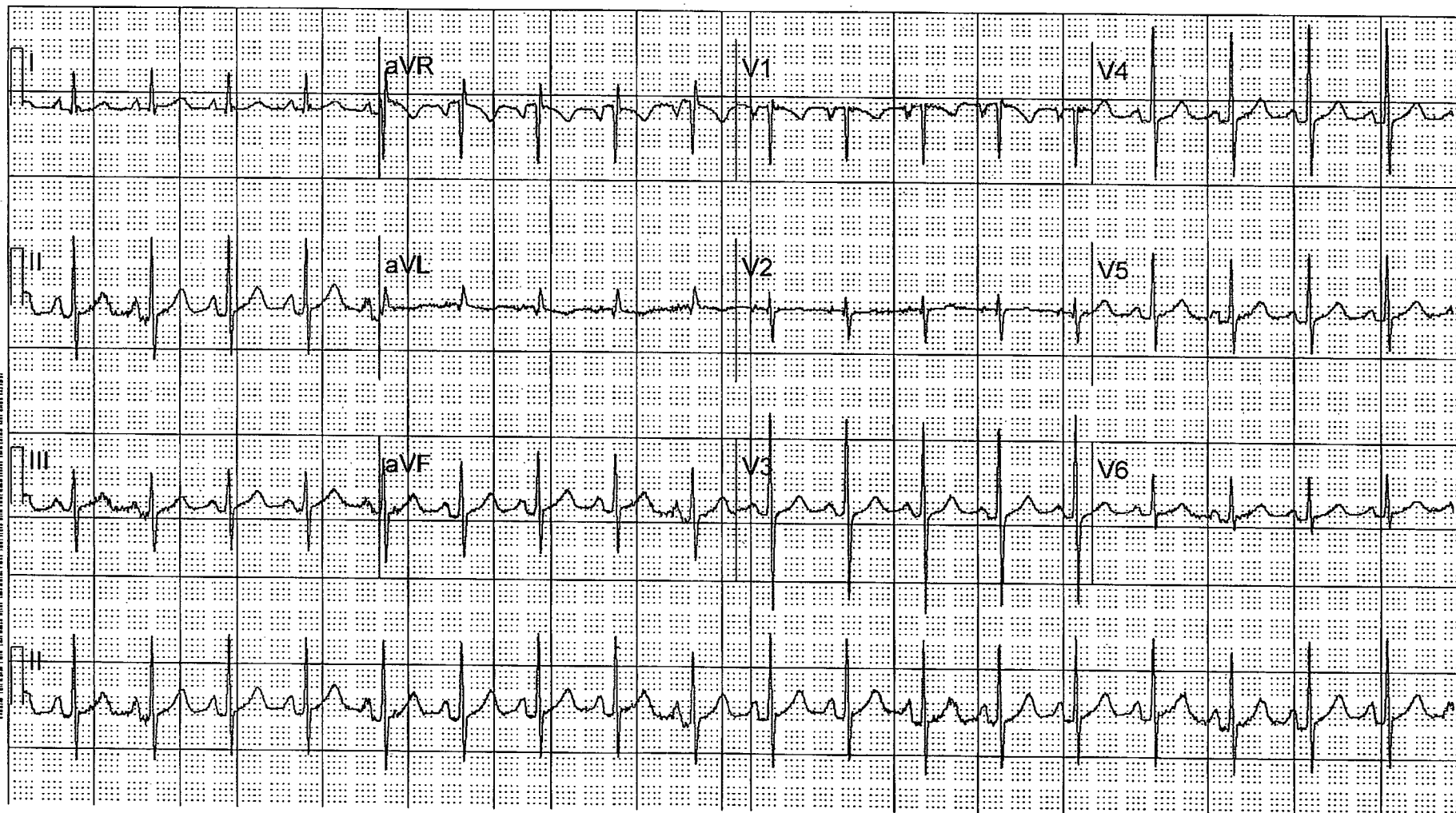
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FARR , WILLIAM G
 MR#: 000478684
 Age: 69 years Male Caucasian
 Room: CP30
 Tech: DOB: [REDACTED]
 Priority: EKG
 Ord. Dr.: Micah Roy
 ACC#: 1216200102
 Com: Bedside Monitor 12 Lead ECG
 Bed: CP30
 Dept: EC-ChestPain
 Time: 11.16.00 Date: 06/10/12
 Inst: SPARTANBURG REG.MED.CENT.

Vent rate: 111 SINUS TACHYCARDIA
 RR : 540 ABNORMAL RHYTHM ECG
 --Durations-- tachy---no changes
 P :
 QRS: 70
 --Intervals--
 PR : 134
 QT : 318
 QTcH: 407
 QTd:
 --Axes--
 P : 58
 QRS: 31 Confirmed test: Dr. Micah Roy
 T : 70

Speed: 25 mm/s Limb Lead Gain: 10.0 mm/mV Chest Lead Gain: 10.0 mm/mV Filters(s): Notch Off Artifact Off Stable Off



ECG Printed 06/10/12 18.20.09

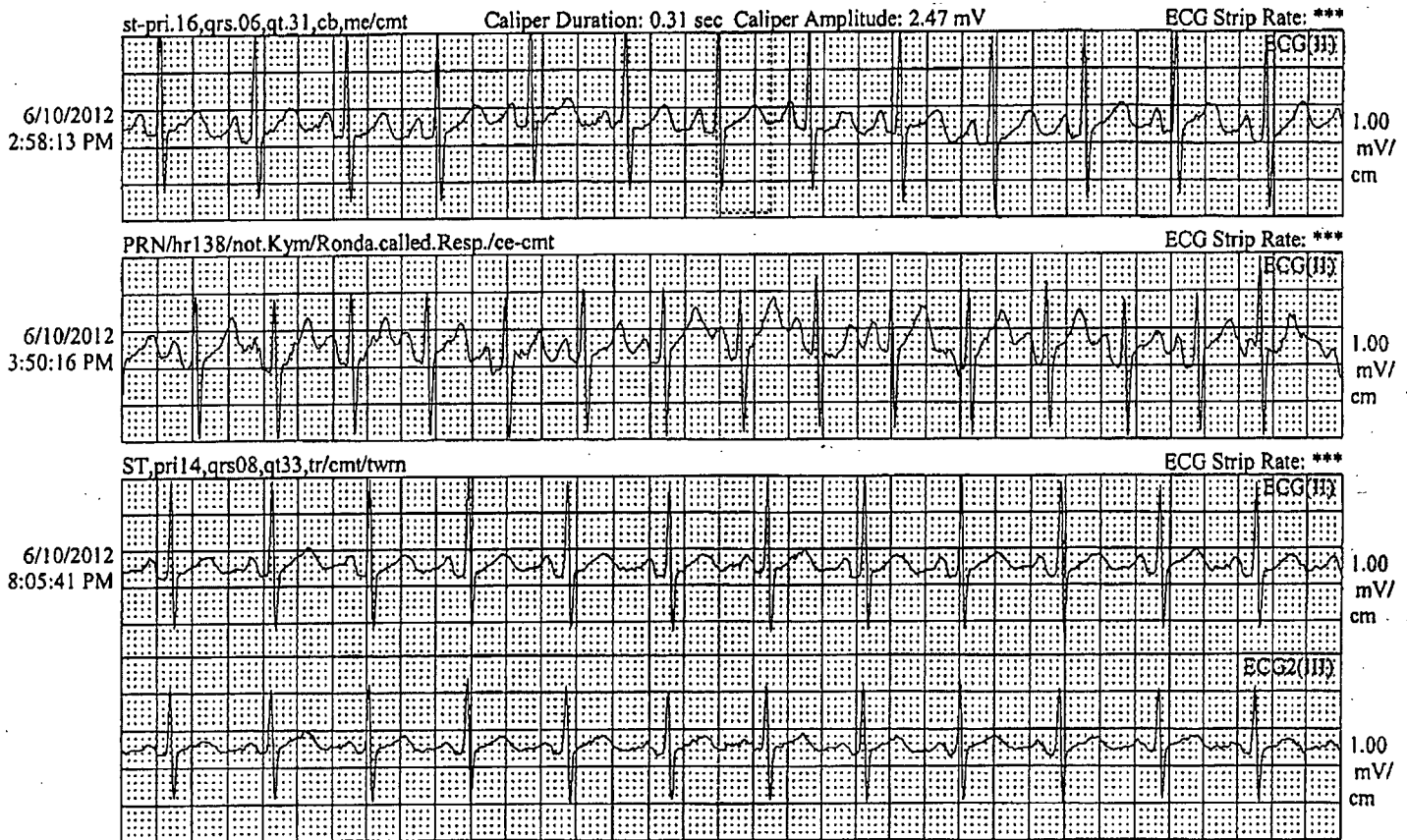
Transcribed By: DR. MICAH ROY 06/10/12 18.19.54

CONFIRM

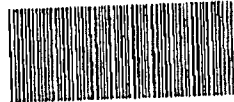
SLMD QTcH=(Hodges)
 PRINTED BY: DR30588

Name: FARR, W. LITTLEFIELD, FULL
ID: UV2_10 3
Account #:
DOB:
Location: 5 Heart
Monitor: 8528

Saved Event Report
Printed on 6/11/2012 5:06:41 AM

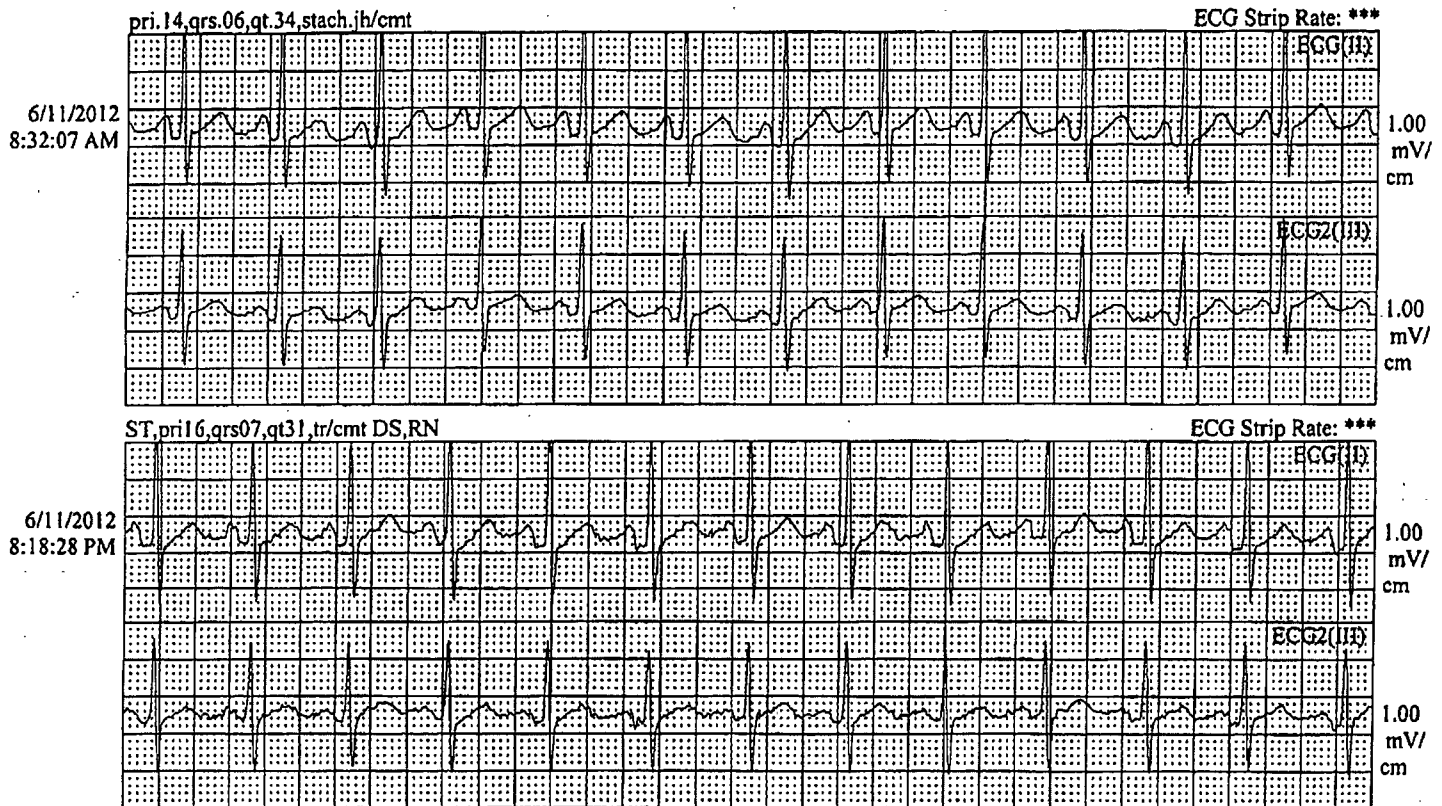


1216200102 000478684 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



Saved Event Report
Printed on 6/12/2012 12:20:57 AM

Name: FARR, W 'TTL1203, FULL
ID: UV2_10' 3
Account #:
DOB:
Location: 5 Heart
Monitor: 8528



1216200102 000-478684 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



SPARTANBURG REGIONAL

06/12/2012 21:11

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Surgical Checklist

From 06/10/2012 11:21 To 06/12/2012 15:09

narrative

06/10/2012 00:00 TO 06/10/2012 23:59

Legend Charting

06/10/2012 16:07

surgcl vs (22297)

BP #1 = 118/90 R arm

Pulse #1 = 113 cardiac monitor

Resp = 22 visual

Wt. (kg) = 55.701098kg

Barber, George W., CCA
06/10/2012 16:08
Barber, George W., CCA
06/10/2012 16:08
Barber, George W., CCA
06/10/2012 16:08
Barber, George W., CCA
06/10/2012 16:08

06/10/2012 20:00

surgcl vs (22297)

BP #1 = 106/60 R arm

Pulse #1 = 104 cardiac monitor

Resp = 20 visual

Temp (F) = 97.7F oral

Mosley, Victoria M., PCT
06/10/2012 20:35
Mosley, Victoria M., PCT
06/10/2012 20:35
Mosley, Victoria M., PCT
06/10/2012 20:35
Mosley, Victoria M., PCT
06/10/2012 20:35

06/11/2012 00:00 TO 06/11/2012 23:59

Legend Charting

06/11/2012 00:00

surgcl vs (22297)

BP #1 = 120/68 L arm

Pulse #1 = 100 cardiac monitor

Resp = 20 visual

Temp (F) = 97.4F oral

Mosley, Victoria M., PCT
06/11/2012 00:48
Mosley, Victoria M., PCT
06/11/2012 00:48
Mosley, Victoria M., PCT
06/11/2012 00:48
Mosley, Victoria M., PCT
06/11/2012 00:48

06/11/2012 06:37

surgcl vs (22297)

Wt. (kg) = 54.6kg

Mosley, Victoria M., PCT
06/11/2012 06:37

06/11/2012 08:01

surgcl vs (22297)

BP #1 = 130/90 L arm

Pulse #1 = 107 cardiac monitor

Resp = 20 visual

Temp (F) = 97.8F axillary

Barber, George W., CCA
06/11/2012 08:02
Barber, George W., CCA
06/11/2012 08:02
Barber, George W., CCA
06/11/2012 08:02
Barber, George W., CCA
06/11/2012 08:02

06/11/2012 11:25

surgcl vs (22297)

BP #1 = 102/70 L arm

Pulse #1 = 124

Barber, George W., CCA
06/11/2012 11:28
Barber, George W., CCA
06/11/2012 11:28

Name: FARR, WILLIAM G.

Age: 69 yr

Acct: 1216200102

Opt Out:

Gender: M

MRN: 000478684

Physician: Littlefield, Ronald H., MD

Rm-Bed: 8528 - A

Admit Dt: 06/10/2012 14:57 DOB: [REDACTED]

PRINTED BY: DB30588

DATE 7/18/2013

SPARTANBURG REGIONAL

06/12/2012 21:11

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Surgical Checklist

From 06/10/2012 11:21 To 06/12/2012 15:09

narrative

06/11/2012 00:00 TO 06/11/2012 23:59

Legend Charting

06/11/2012 11:25

surgcl vs (22297)

Resp = 22

Temp (F) = 97.2F axillary

Barber, George W., CCA
 06/11/2012 11:28
 Barber, George W., CCA
 06/11/2012 11:28

06/11/2012 15:27

surgcl vs (22297)

BP #1 = 112/80 L arm

Pulse #1 = 103 cardiac monitor

Resp = 20 visual

Barber, George W., CCA
 06/11/2012 15:28
 Barber, George W., CCA
 06/11/2012 15:28
 Barber, George W., CCA
 06/11/2012 15:28

06/11/2012 20:00

surgcl vs (22297)

BP #1 = 116/62 L arm

Pulse #1 = 115 cardiac monitor

Resp = 18 visual

Temp (F) = 96.3F axillary

Mosley, Victoria M., PCT
 06/11/2012 20:43
 Mosley, Victoria M., PCT
 06/11/2012 20:43
 Mosley, Victoria M., PCT
 06/11/2012 20:43
 Mosley, Victoria M., PCT
 06/11/2012 20:43

06/12/2012 00:00 TO 06/12/2012 23:59

Legend Charting

06/12/2012 08:03

surgcl vs (22297)

BP #1 = 136/80 L arm

Pulse #1 = 111 cardiac monitor

Resp = 20 visual

Temp (F) = 96.6F axillary

Barber, George W., CCA
 06/12/2012 08:05
 Barber, George W., CCA
 06/12/2012 08:05
 Barber, George W., CCA
 06/12/2012 08:05
 Barber, George W., CCA
 06/12/2012 08:05

06/12/2012 11:58

surgcl vs (22297)

BP #1 = 112/70 L arm

Pulse #1 = 114 cardiac monitor

Resp = 22 visual

Temp (F) = 96.4F axillary

Barber, George W., CCA
 06/12/2012 11:59
 Barber, George W., CCA
 06/12/2012 11:59
 Barber, George W., CCA
 06/12/2012 11:59
 Barber, George W., CCA
 06/12/2012 11:59

Name: FARR, WILLIAM G.

Age: 69 yr

Acct: 1216200102

Opt Out:

Gender: M

MRN: 000478684

Physician: Littlefield, Ronald H., MD

Rm-Bed: 8528 - A

Admit Dt: 06/10/2012 14:57 DOB: 06/10/1943

PRINTED BY: DB30588

DATE 7/18/2013

06/11/12 0056

RESPIRATORY THERAPY

~ Original
-1206-

528-A FARR, WILLIAM, G

IP DOB: [REDACTED] 69Y Sex: M

Act: S1216200102 Unit: S000478684

Phys: LITTLEFIELD, RONALD. H

adm: 06/10/12 1457

JHN

Performed: 06/10/12 1130 WW

RT Text: Complete

Pract Name: WHITEFIELD, WALTER

6/10 RESPIRATORY NOTES

157 See Respiratory Care Notes.

POINT OF CARE TESTING

Performed: 06/10/12 1418 WW

T Progress Note: Complete

Pract Name: WHITEFIELD, WALTER

6/10 Point of Care Testing consisted of analysis., puncture

1428

CARE PLAN

Performed: 06/10/12 1615 CAC

RT Text: Complete

Pract Name: COOK, CRYSTAL A

6/10 RESPIRATORY NOTES

840 See Respiratory Care Notes.

OXYGEN ASSESSMENT

Performed: 06/10/12 1615 CAC

T Progress Note: Complete

Pract Name: COOK, CRYSTAL A

6/10 Oxygen this shift was shift usage., O2 rounds sat. check

1840

All Patient Notes (External)

06/12/12 0141

RESPIRATORY THERAPY

~ Original
-1207-

8528-A FARR, WILLIAM, G

IP DOB: [REDACTED] 69Y Sex: M

Act: S1216200102 Unit: S000478684

Phys: LITTLEFIELD, RONALD H

Adm: 06/10/12 1457

HHN PRN

Performed: 06/11/12 0142 SJM

RT Progress Note: Complete

Pract Name: MELTON, SARAH J

06/11 HHN given.

0315

TRANSPORT AIRWAY MGMT REQUEST

Performed: 06/11/12 0142 SJM

RT Progress Note: Complete

Pract Name: MELTON, SARAH J

06/11 Time was patient standby/transport 45 minutes.

0315

OXYGEN ASSESSMENT

Performed: 06/11/12 0142 SJM

RT Progress Note: Complete

Pract Name: MELTON, SARAH J

06/11 Oxygen this shift was shift usage., O2 rounds sat. check

0312

POINT OF CARE TESTING

Performed: 06/11/12 0200 SJM

RT Progress Note: Complete

Pract Name: MELTON, SARAH J

06/11 Point of Care Testing consisted of analysis., puncture

0315

BIPAP MANAGEMENT

Performed: 06/11/12 0215 SJM

RT Progress Note: Complete

Pract Name: MELTON, SARAH J

06/11 BiPAP was initiated.

0314 BiPAP Management was initial day.

IPPB

Cancelled: 06/11/12 0608 ALS

PRN TX NOT CALLED FOR

RT Text: Complete

Pract Name: SPURLIN, ASHLEY L

06/11 RESPIRATORY NOTES

0608 See Respiratory Care Notes.

BIPAP MANAGEMENT

Performed: 06/11/12 0800 KRP

RT Progress Note: Complete

Pract Name: PORTER, KARLA R

06/11 BiPAP was initiated.

1032 Adjustments made one.

BiPAP Management was initial day.

OXYGEN ASSESSMENT

Performed: 06/11/12 0920 DRD

RT Progress Note: Complete

Pract Name: DANN, DANA R

06/11 Oxygen this shift was shift usage., O2 rounds sat. check

1128 Adjustment was oxygen setting change 1.

All Patient Notes (External)

06/12/12 1844

RESPIRATORY THERAPY

~ Original

~~-1208-~~

SI FARR, WILLIAM, G
Act: S1216200102 Unit: S000478684
dm: 06/10/12 1457 Dis: 06/12/12 1509

IP DOB: 69Y Sex: M
Phys: LITTLEFIELD, RONALD H

CARE PLAN

RT Text: Complete

6/12 RESPIRATORY NOTES

844 See Respiratory Care Notes.

Performed: 06/12/12 0730 LNT

Pract Name: TURNER, LASINDA N

All Patient Notes (External)
rom 06/12/12 0730 through 06/12/12 0730

06/12/12 1853

RESPIRATORY THERAPY

~ Original

~~-1209-~~

HSI FARR, WILLIAM, G
Act: S1216200102 Unit: S000478684
Adm: 06/10/12 1457 Dis: 06/12/12 1509

IP DOB: [REDACTED] 69Y Sex: M
Phys: LITTLEFIELD, RONALD H

HHN PRN

Cancelled: 06/12/12 1823 ARD
PATIENT DISCHARGED
Pract Name: TURNER, LASINDA N

RT Progress Note: Complete
06/12 HHN given.
1853

All Patient Notes (External)
From 06/12/12 1823 through 06/12/12 1823

SPARTANBURG REGIONAL

06/12/2012 21:11

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Respiratory Services - SRMC/Village
 From 06/10/2012 11:21 To 06/12/2012 15:09

narrative

06/10/2012 00:00 TO 06/10/2012 23:59

Legend Charting

06/10/2012 16:15

Assessment (30538)

Assessment Phase = Initial

Diagnosis = resp distress, short of breath

Currnt Resp Ther = Bronchodil Protc, O2 protocol

LOC = alert oriented

Level of Activity = bedrest

Breath Sounds R = diminished

Breath Sounds L = diminished

Cough = strong non-prod

Work of Breathing = increased

Breathing Pattern = SOB

Smoking History = smoking history

Oxygen/Liter = 10L oxymizer

SpO2 = 94%

Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31

Oxygen (33185)

O2 Therapy = checked

O2 Modality = oxymizer

O2 Amount = 10L/minute

SpO2 = 94%

Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31

Resp Treatments (33186)

HHN - HHN Tx Performed = Yes

HHN - HHN Circuit = new

HHN - HHN Med Admin = Duoneb

HHN - HHN Route = mouthpiece

Patient Info - HR Before Tx = 122beats/min

Patient Info - HR During Tx = 122beats/min

Patient Info - HR After Tx = 120beats/min

Patient Info - RR Before Tx = 26rate/min

Patient Info - RR During Tx = 26rate/min

Patient Info - RR After Tx = 26rate/min

Breath Snds Pre

All Lobes = diminished

Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31
 Cook, Crystal A., CRT
 06/10/2012 18:31

Name: FARR, WILLIAM G.

Age: 69 yr

Acct: 1216200102

Opt Out:

Gender: M

MRN: 000478684

Physician: Littlefield, Ronald H., MD

Rm-Bed: 8528 - A

Admit Dt: 06/10/2012 14:57 DOB: 07/08/1942

PRINTED BY: DB30588

DATE 7/18/2013

SPARTANBURG REGIONAL

06/12/2012 21:11

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Respiratory Services - SRMC/Village
 From 06/10/2012 11:21 To 06/12/2012 15:09

narrative

06/11/2012 00:00 TO 06/11/2012 23:59

Legend Charting

06/11/2012 02:15

Ventilation (33204)

CPAP/BIPAP - CPAP/BIPAP Mgmt = Initiated

CPAP/BIPAP - Machine Type = Vision

CPAP/BIPAP - Mask Type = full-face

CPAP/BIPAP - Mode = spontaneous, timed

CPAP/BIPAP - Set Rate = 12breath/min

CPAP/BIPAP - IPAP = 10cmH2O pres

CPAP/BIPAP - EPAP = 5cmH2O pres

CPAP/BIPAP - FIO2 = 100%

CPAP/BIPAP - Alarms = on and audible

CPAP/BIPAP - SpO2 = 95%

Patient - Measured Vt = 664

Patient - Total RR = 29rate/min

Patient - VE = 19L/minute

Patient - PP = 15

Patient - SpO2 = 95%

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

Melton, Sarah J., RRT

06/11/2012 02:49

06/11/2012 08:25

Ventilation (33204)

CPAP/BIPAP - CPAP/BIPAP Mgmt = checked

CPAP/BIPAP - Machine Type = Vision

CPAP/BIPAP - Mask Type = full-face

CPAP/BIPAP - Mode = spontaneous, timed

CPAP/BIPAP - Set Rate = 12breath/min

CPAP/BIPAP - IPAP = 10cmH2O pres

CPAP/BIPAP - EPAP = 5cmH2O pres

CPAP/BIPAP - FIO2 = 80%

Notes: decreased fiO2 from 100 to 80%. Nurse aware.

CPAP/BIPAP - Alarms = on and audible

CPAP/BIPAP - SpO2 = 98%

Patient - Measured Vt = 432

Patient - Total RR = 22rate/min

Patient - VE = 10L/minute

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Porter, Karla R., RRT

06/11/2012 08:53

Name: FARR, WILLIAM G.

Age: 69 yr

Acct: 1216200102

Opt Out:

Gender: M

MRN: 000478684

Physician: Littlefield, Ronald H., MD

Rm-Bed: 8528 - A

Admit Dt: 06/10/2012 14:57

DOB: [REDACTED]

PRINTED BY: DB30588

DATE

7/18/2013

SPARTANBURG REGIONAL
Respiratory Services - SRMC/Village
From 06/10/2012 11:21 To 06/12/2012 15:09

06/12/2012 21:11
Page 4 of 6

narrative

06/11/2012 00:00 TO 06/11/2012 23:59

Legend Charting

06/11/2012 08:25

Ventilation (33204)

Patient - PP = 15

Patient - SpO2 = 98%

Porter, Karla R., RRT
06/11/2012 08:53
Porter, Karla R., RRT
06/11/2012 08:53

06/11/2012 09:20

Oxygen (33185)

O2 Therapy = changed

Notes: placed Bipap on standby pt request to eat, Rn notified to call RRT if pt desats
O2 Modality = oxymizer

O2 Amount = 15L/minute

SpO2 = 90%

Dann, Dana R., RRT
06/11/2012 10:40

Dann, Dana R., RRT
06/11/2012 10:40
Dann, Dana R., RRT
06/11/2012 10:40
Dann, Dana R., RRT
06/11/2012 10:40

Ventilation (33204)

CPAP/BIPAP - CPAP/BiPAP Mgmt = standby

Dann, Dana R., RRT
06/11/2012 10:40

06/11/2012 11:30

Oxygen (33185)

O2 Therapy = changed

O2 Modality = non-rebreath

O2 Amount = 15L/minute

SpO2 = 94%

Dann, Dana R., RRT
06/11/2012 14:26
Dann, Dana R., RRT
06/11/2012 14:26
Dann, Dana R., RRT
06/11/2012 14:26
Dann, Dana R., RRT
06/11/2012 14:26

Ventilation (33204)

CPAP/BIPAP - CPAP/BiPAP Mgmt = standby

Dann, Dana R., RRT
06/11/2012 14:26

06/11/2012 14:15

Ventilation (33204)

CPAP/BIPAP - CPAP/BiPAP Mgmt = standby

Dann, Dana R., RRT
06/11/2012 14:26

06/11/2012 17:38

Ventilation (33204)

CPAP/BIPAP - CPAP/BiPAP Mgmt = standby

Dann, Dana R., RRT
06/11/2012 17:38

06/11/2012 20:00

Oxygen (33185)

O2 Therapy = checked

O2 Modality = non-rebreath

O2 Amount = 15L/minute

Ruskin, Matthew , RCP
06/11/2012 22:11
Ruskin, Matthew , RCP
06/11/2012 22:11
Ruskin, Matthew , RCP
06/11/2012 22:11

Name: FARR, WILLIAM G.

Age: 69 yr

Acct: 1216200102

Opt Out:

Gender: M

MRN: 000478684

Physician: Littlefield, Ronald H., MD

Rm-Bed: 8528 - A

Admit Dt: 06/10/2012 14:57 DOB: 07/06/1942

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SPARTANBURG REGIONAL

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Respiratory Services - SRMC/Village
From 06/10/2012 11:21 To 06/12/2012 15:09

narrative

06/11/2012 00:00 TO 06/11/2012 23:59

Legend Charting

06/11/2012 20:00

Oxygen (33185)

SpO2 = 90%

Ruskin, Matthew , RCP
06/11/2012 22:11

06/11/2012 22:11

Ventilation (33204)

CPAP/BIPAP - CPAP/BiPAP Mgmt = standby

Ruskin, Matthew , RCP
06/11/2012 22:11

06/12/2012 00:00 TO 06/12/2012 23:59

Legend Charting

06/12/2012 04:00

Ventilation (33204)

CPAP/BIPAP - CPAP/BiPAP Mgmt = standby

Davella, April R., RCP
06/12/2012 06:34

Notes: pt does not want to wear.

06/12/2012 07:30

Assessment (30538)

Assessment Phase = reassessment

Diagnosis = resp distress, short of breath

Curmnt Resp Ther = Bronchodil Protic, O2 protocol

LOC = alert oriented

Level of Activity = bedrest

Breath Sounds R = wheezing, rhonchi

Breath Sounds L = wheezing, rhonchi

Cough = strong non-prod

Smoking History = smoking history

Oxygen/Liter = 15L non-rebreath

SpO2 = 95%

Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
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Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32

Oxygen (33185)

O2 Therapy = checked

O2 Modality = non-rebreath

O2 Amount = 15L/minute

SpO2 = 95%

Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32
Turner, Lasinda N., RCP
06/12/2012 11:32

Ventilation (33204)

CPAP/BIPAP - CPAP/BiPAP Mgmt = standby

Turner, Lasinda N., RCP
06/12/2012 11:32

Notes: pt refused at this time

Name: FARR, WILLIAM G.

Age: 69 yr

Acct: 1216200102

Opt Out:

Gender: M

MRN: 000478684

Physician: Littlefield, Ronald H., MD

Rm-Bed: 8528 - A

Admit Dt: 06/10/2012 14:57 DOB: [REDACTED]

PRINTED BY: DB30588

DATE 7/18/2013

SPARTANBURG REGIONAL

06/12/2012 21:11

Page 6 of 6

Respiratory Services - SRMC/Village
From 06/10/2012 11:21 To 06/12/2012 15:09

narrative

06/12/2012 00:00 TO 06/12/2012 23:59

Legend Charting

06/12/2012 07:30

Resp Treatments (33186)

HHN - HHN Tx Performed = Yes

Notes: pt called for breathing tx due to sob. pt sitting up on side of bed watching tv. spo2 95% on nrb at 15 lpm. hhn tx given.
HHN - HHN Med Admin = Duoneb

HHN - HHN Route = mouthpiece

Patient Info - HR Before Tx = 101beats/min

Patient Info - HR During Tx = 110beats/min

Patient Info - HR After Tx = 111beats/min

Patient Info - RR Before Tx = 26rate/min

Patient Info - RR During Tx = 24rate/min

Patient Info - RR After Tx = 24rate/min

Breath Snds Pre

All Lobes = wheezes, coarse

Breath Snds Post

All Lobes = improved; wheezes

Breathing Pattern = normal

Pain = no pain

Outcome = no adverse react

Appearance = no distress

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Turner, Lasinda N., RCP
06/12/2012 11:32

Name: FARR, WILLIAM G.

Age: 69 yr

Acct: 1216200102

Opt Out:

Gender: M

MRN: 000478684

Physician: Littlefield, Ronald H., MD

Rm-Bed: 8528 - A

Admit Dt: 06/10/2012 14:57

DOB: 07/06/1942

PRINTED BY: DB30588

DATE

7/18/2013

06/13/12 0327

RESPIRATORY THERAPY

~ Original
~~-1216-~~

ISI FARR, WILLIAM, G
Act: S1216200102 Unit: S000478684
adm: 06/10/12 1457 Dis: 06/12/12 1509

IP DOB: 69Y Sex: M
Phys: LITTLEFIELD, RONALD H

CARE PLAN

Text: Complete
6/12 RESPIRATORY NOTES
1844 See Respiratory Care Notes.

Cancelled: 06/12/12 0730 LNT
PATIENT DISCHARGED
Pract Name: TURNER, LASINDA N

HN PRN

PT Progress Note: Complete
6/12 HHN given.
853

Cancelled: 06/12/12 1823 ARD
PATIENT DISCHARGED
Pract Name: TURNER, LASINDA N

All Patient Notes (External)
from 06/12/12 0000 through 06/12/12 2359

CONSULTING MD

ATTENDING PHYSICIAN				CONSULTING PHYSICIAN				ICD-9-CM									
PRINCIPAL DIAGNOSIS																	
ADDITIONAL DIAGNOSES																	
PRINCIPAL SURGERY																	
ADDITIONAL SURGERY																	
DATE																	
OTHER SIGNATURE								ACCOMMODATION									
OTHER SIGNATURE								☐ C.C.U. ☐ I.C.U. ☐ NEURO. ☐ POST C.C.U.									
ASSEMBLED				CODED		ANALYZED		FINAL CHECK		CORPORATE ID							
06/21/12										00348263							
SPARTANBURG REGIONAL MEDICAL CENTER																	
DISCHARGED				DISCHARGE DISPOSITION				UNIT NUMBER									
DATE 06/18/12 TIME 12				☒ ALIVE ☐ AUTOPSY ☐ DEATH +48 ☐ DEATH -48 ☐ STILLBORN ☐ TRANSFERRED				000-478684									
ACCOUNT NO.		ADMISSION DATE / TIME		FC	DATE OF BIRTH	AGE	SEX	RACE	MS	SERVICE	STATION	ROOM NO.	ACC	PAT. TYPE			
S 1216401412		06/12/12 1517		CI		69Y	M	1	M	MED	HOS	HH09-A	R	IPH			
RESIDENT / REFERRING DOCTOR				ADMITTING DOCTOR				ACCIDENT / WORK RELATED				ACCIDENT DATE / TIME		ADM. TYPE / SOURCE			
SNIPES, GARRETT E				SNIPES, GARRETT E				NO						2 2			
PATIENT INFORMATION				SOC. SEC. NO.				PATIENT EMPLOYER				TELEPHONE NO.					
FARR, WILLIAM G 1032 JONESVILLE LOCKHART HWY UNION SC 29379				[REDACTED] [REDACTED] (864)251-0531				RETIRED									
GUARANTOR NAME AND ADDRESS				SOC. SEC. NO.				GUARANTOR EMPLOYER				TELEPHONE NO.					
FARR, WILLIAM G 1032 JONESVILLE LOCKHART HWY UNION SC 29379				(864)251-0531 RELATION SELF				RETIRED				OCCUPATION RETIRED					
RELATIVE 1				(864)426-5765				RELATIVE EMPLOYER				UNEMPLOYED					
FARR, DELORIS 1032 JONESVILLE LOCKHART UNION SC 29379				SPOUSE													
INSURANCE 1				INSURANCE 2				INSURANCE 3				INSURANCE 4					
HOSPICE HOUSE ONLY				1													
SPARTANBURG HOSPICE HOU 999				SC 29303 FARR, WILLIAM G													
PRESENTING COMPLAINT				ARRIVAL MODE		PUB / VAL		ADV. DIR.		PAT CLA		DENOM		ADM. BY			
V66.7-ENCOUNTR PALLIATIVE CARE						N		NO				BAP		KMB			
STAFF ALERT:						OBSERVATION: ☐ YES ☐ NO											
PREVIOUS ENCOUNTER NAME / DATE / TYPE						06/10/12						IP					
FARR, WILLIAM G																	



SPARTANBURG

Regional Healthcare System

☐ SRMC☐ SHRC☐ VH

Spartanburg Regional Hospice Home

Admission Report

1430

Signature of Staff member taking report: Ashleigh Puttall RN Date: 6/12/12☒ Current ☐ New Regional Hospice patient ☐ Other agencyPatient coming from: ☐ Home ☒ Hospital ☐ Facility 50Report given by: PRUCE, RN Contact number: 65757Pt. Name: William Farr Diagnosis: NSCLCA Age: 69Family contact name and number: Brian Farr 415-1662 - son (POA)Allergies: NKAHt.: 65" Wt.: 54.6 Kg Recent PPD: ☐ Yes ☒ No If yes, provide documentationReason for Admission: symptom managementGoal of Admission: home hospice**Pain Rating:**Patient Pain Goal: Ø problem

Current reported pain (0-10 scale): _____ Location: _____

Interventions tried: _____

Medications given and time of last dose: Morphine/AtivanL1330**Nausea/Vomiting:**☐ Yes ☒ No Interventions tried: _____

Medications given and time of last dose: _____

Dyspnea:☐ None ☐ Mild ☒ Moderate ☐ Severe O2: 15L Lung Sounds: _____Interventions tried: non-rebreather

Medications given and time of last dose: _____

State of Consciousness:A&O x 3 ☐ Confused ☒ Lethargic ☐ Unresponsive ☐ Anxiety/Restlessness ☐ Other _____

Medications given and time of last dose: _____

Intake:☐ NPO ☐ Clear Liquids ☐ Full Liquids ☐ Soft ☒ General Diet**Safety:**☐ Abuse/Neglect (Actual/Potential Risks or History): Ø

A Puttall RN
Signature

6/12/12
Date

Patient Label

1216401412 000-478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E



IV/SQ Access:

☒ Yes ☐ No Type: PAC Location: (P) SC Placement Date: _____
Date last Flushed: _____

Elimination:

☒ Continent ☐ Incontinent ☐ Foley ☐ Depends
Date of Last BM: _____ ☐ Constipation ☐ Diarrhea ☐ Other

Interventions tried: _____

Medications given and time of last dose: Colostomy - colon resection E colon CA

Infection:

Type of infection: φ Location: _____ Isolation needs: _____
Medications given and time of last dose: _____

Edema:

☐ Yes ☒ No Location: _____
Interventions tried: _____
Medications given and time of last dose: _____

Skin Integrity:

Describe: intact
Wound care needs: _____
☐ Wound Vac - If yes, discuss discontinuing prior to admission

Activity: ☐ Independent ☒ Bedrest ☐ Chair ☐ W/C ☐ Walker ☐ Cane ☐ Hoyer
☐ Orthopedic devices - unable to accommodate traction

Safety: ☐ Recent Fall Date: φ Injuries: _____

Fingersticks: ☐ Yes ☒ No Frequency: _____ Insulin: _____
Amount: _____ Last dose given at: _____

Comments:

Littlefield
Feb. Lung CA (P) 4, M lobectomy
Nicotine Patch => still wants cigarette

APutell RN
Signature

6/12/12
Date

Patient Label

1216401412 000-478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E



PATIENT NAME: FARR, WILLIAM G
MEDICAL RECORD #: 478684
DATE OF BIRTH: [REDACTED]
ACCOUNT NUMBER: 1216401412
DATE OF ADMISSION: 06/12/2012
ROOM:

HH09

HISTORY OF PRESENT ILLNESS

Mr. Farr is a 69-year-old man with a history of complex end-stage lung disease. He had baseline COPD and has had it for some time with progressive worsening. In addition, he had stage II non-small cell lung cancer in October 2010 and had right middle and lower lobectomies. He also had chemo radiation, but stopped after cycle 5 due to toxicity. He has had several admissions to the hospital for exacerbations of dyspnea and respiratory failure and CT scanning shows extensive bilateral infiltrates which have been difficult to assess precisely as far as infection versus lymphangitic carcinoma. That mystery still remains, despite multiple consultants, including infectious disease, pulmonology and oncology. Nevertheless, the bigger picture is of this man's overall performance status and symptom profile had been worsening. He is very cachectic and is quite dyspneic even at rest. He was discharged from the hospital on the 5th of June, admitted to hospice and returned to the hospital on the 10th of June after his family called 911. He was profoundly dyspneic, white count was elevated and chest x-ray did show bilateral infiltrates. He had a brief hospital stay, and after discussion of the primary care team with the patient, decision was made to transfer to the hospice home. He had couple of days of vancomycin and then was switched to Avelox by his primary care physician, Dr. Littlefield, who transferred him here on Avelox. His major symptom at this point is rather severe dyspnea at rest and marked worsening with any exertion. He is not really having pain at this point, and apart from anxiety, he is not really having any other symptoms. He transfers to the hospice home for symptom management, presumably as a conduit to return into the home setting with home hospice.

PAST MEDICAL HISTORY

Positive for lung cancer with previous lung resection; COPD; history of colon cancer with colon resection and colostomy; history of non-Q wave myocardial infarction; dyslipidemia by history.

SURGICAL HISTORY

Right upper lobe and right middle lobe lobectomy.

MEDICATIONS

Reviewed on his transfer forms.

ALLERGIES

None.

FAMILY HISTORY

Noncontributory.

SOCIAL HISTORY

He was in a convenience store business. He has lived in Union his entire life. He is married and has 2 adult children. Spiritual: I do not have any information on that.

REVIEW OF SYSTEMS

As above.

PHYSICAL EXAMINATION

VITAL SIGNS: Temperature is 97.4, pulse is 101 at rest, respirations 29, BP is 114/82.

GENERAL: He is an alert man. He is apparently air hungry.

SKIN: Clear.

LYMPHATICS: Negative.

HEENT: PERRLA. Mucous membranes are moist.

CHEST: Reveals increased AP chest diameter.

LUNGS: Reveal bilateral inspiratory rhonchi and rales with a few end-expiratory wheezes.

CARDIAC: Regular rhythm with tachycardia.

ABDOMEN: Soft, scaphoid. He is using accessory muscles of ventilation, nontender.

GENITALIA: Normal male.

EXTREMITIES: Symmetrical. Distal extremities are warm and well perfused. There is no peripheral edema.

NEUROLOGIC: Shows no focal neurologic signs.

ASSESSMENT

This is a 69-year-old man with acute-on-chronic respiratory failure, end-stage chronic obstructive pulmonary disease and very likely advanced lung cancer, though that is not entirely certain. He is admitted for symptom management and as a conduit to return home with home hospice.

PPS is 30%, New York Heart Association class IV.

PROGNOSIS FOR LIFE EXPECTANCY

Ill-defined at this point, but I would say would certainly be in the range of weeks to months at the outside.

PLANS

1. Symptom management in usual fashion with small doses of opioids and supplement with short-acting opioids if need be.
2. Standard management for end-stage COPD, bronchodilators, steroids, etc.
3. We will continue course of Avelox as started.
4. I had an extensive discussion with the patient's family initially and then with the family and the patient to clarify goals of care. Mr. Farr's daughter is not completely satisfied with the hospice plan of care, but it is allowing her father to choose and the rest of the family seems generally supportive, if rather faintly so, at this point. They still seem to be harboring hopes that he is going to get substantially better.
5. We will try to provide support to the family as they are willing to accept, particularly social and spiritual support, through this difficult time for them.

Dictated By: SNIPES, GARRETT E
Dictated For (If Applicable):

D:06/12/2012 17:16:05
T:06/12/2012 22:13:37/un
1257589/1097770

Cc: SNIPES, GARRETT E, Attending Physician
H & P Page 3 of 3
FARR, WILLIAM G
478684

Note: Document is draft unless signed. <END FOOTER>

Authenticated by Garrett Snipes, MD. On 06/15/2012 07:20:42 PM

Order Confirmation Report - FARR, WILLIAM G
 DEPT: HOS ROOM: HH09-A MR: 000478684
 Ordered by: Unit Secre BIGELOW, KENDRA R
 Entered by: US BIGELOW, KENDRA R - 06/12/12 15:33
 Order mode: Written - Session Id:18951514

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy		

HEODEPT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
1	Started	DIAGNOSIS:	CONTIN	ROUTINE		06/12 15:32	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Primary malignant neoplasm of lung (162.9)					
2	Started	DIAGNOSIS:	CONTIN	ROUTINE		06/12 15:32	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Adenocarcinoma of lung (162.9)					
3	Started	DIAGNOSIS:	CONTIN	ROUTINE		06/12 15:32	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Dyspnea (786.09)					
4	Started	DIAGNOSIS:	CONTIN	ROUTINE		06/10 15:32	Indefinite
		Category: Medical					
		Enter a diagnosis search (part of a name or an ICD9 code): Dyspnea (786.09)					

NOU

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
6	Started	SEND TRAY NOW	ONCE	ASAP	1 Time	06/12 15:33	06/12 15:33
		Enter Diet in Instruction Box					
		INSTRUCTIONS (Enter diet): : mechsoftdiet					

NS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
5	Started	MECHANICAL (SOFT) DIET	M	DINNER		06/12 15:33	
		DIET MODIFIER #1: NO DIET MODIFIER					
		DIET MODIFIER #2: NO DIET MODIFIER					
		DIET MODIFIER #3: NO DIET MODIFIER					

240
 11/13/12
 0702
 1552
 6/12/12

240

FARR, WILLIAM G

Order Confirmation Report - FARR, WILLIAM G

DEPT: HOS ROOM: HH09-A MR: 000478684

Ordered by: MD SNIPES, GARRETT E

Authenticated by: MD SNIPES, GARRETT E - 06/12/12 17:38

Order mode: Direct - Session Id:18952682

ALLERGY

Charted	Allergy name	Type	Reaction	Severity	Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy			

AMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
7	Started	ADMIT TO ADMIT TO: HOSPICE HOME	ONCE	ROUTINE	1 Time	06/12 17:30	06/12 17:30

NS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
5	D/C'd	MECHANICAL (SOFT) DIET	M	DINNER		06/12 15:33	
v2		DIET MODIFIER #1: NO DIET MODIFIER DIET MODIFIER #2: NO DIET MODIFIER DIET MODIFIER #3: NO DIET MODIFIER					
25	Started	REGULAR DIET as tolerated	M	BREAKFAST		06/12 17:30	Indefinite
		DIET MODIFIER #1: NO DIET MODIFIER DIET MODIFIER #2: NO DIET MODIFIER DIET MODIFIER #3: NO DIET MODIFIER					

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
8	Started	VITAL SIGNS	PER ROUTINE	ROUTINE		06/12 17:30	Indefinite
9	Started	CODE STATUS: nurse may assess CODE STATUS CATEGORIES: Cat 3 - DNR	QS	ROUTINE		06/12 17:30	Indefinite
10	Started	IV ACCESS with INT or SQ line as needed for medication administration	PRN	ROUTINE		06/12 17:30	Indefinite
11	Started	NSG:02 PER NASAL CANNULA , oxyimzer or mask @ 2-5 L/min; titrate to comfort	QS	ROUTINE		06/12 17:30	Indefinite
12	Started	NSG:WOUND CARE ; nursing to evaluate and begin wound care as needed	PRN	ROUTINE		06/12 17:30	Indefinite
13	Started	POLEY CATHETER #16 or #18 Fr. as needed for incontinence or retention Indication: Terminal-comfort care	PRN	ROUTINE		06/12 17:30	Indefinite
14	Started	MESSAGE TO NURSING: pt may have the following alternative treatments as desired: aromatherapy, massage therapy, music therapy	QS	ROUTINE		06/12 17:30	Indefinite
27	Started	NURSING: if no bm in 72 hrs, repeat miralax 17 grams, check for impaction and treat appropriately and give bisacodyl 10 mg suppository (see med orders)	PRN	ROUTINE		06/12 17:31	Indefinite
35	Started	MESSAGE TO NURSING: Fan blowing on his face please	ONCE	ROUTINE	1 Time	06/12 17:33	06/12 17:33
36	Started	MESSAGE TO NURSING: Offer massage therapy please	ONCE	ROUTINE	1 Time	06/12 17:34	06/12 17:34
37	Started	MESSAGE TO NURSING: Please review meds with family, and keep them informed of med changes. Thanks.	ONCE	ROUTINE	1 Time	06/12 17:34	06/12 17:34
40	Started	MESSAGE TO NURSING: Please dose prn medications judiciously to preserve alertness to the extent possible and still maintain comfort (goals of care issue). THANKS!!!!	ONCE	ROUTINE	1 Time	06/12 17:37	06/12 17:37

FMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
15	Started	ACETAMINOPHEN for pain or fever > 101 deg. F; may give per rectum instead Dose: 650 MG Route: PO	Q4H PRN	ROUTINE		06/12 17:30	Indefinite

CONTINUED

PRINTED BY: DB30588

Page 1

PERM

DATE

7/18/2013

Order Confirmation Report - FARR, WILLIAM G

DEPT: HOS ROOM: HH09-A MR: 000478684

Ordered by: MD SNIPES, GARRETT E

Authenticated by: MD SNIPES, GARRETT E - 06/12/12 17:38

Order mode: Direct - Session Id:18952682

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
16	Started	ACETAMINOPHEN for pain or fever > 101 deg. F; may give po instead	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 650 MG					
		Route: PR					
17	Started	ARTIFICIAL TEARS EYE DROPS ; keep at bedside; family may administer as needed	PRN AS DIR	ROUTINE		06/12 17:30	Indefinite
		Dose: 1-2 DROP					
		Route: EA EYE					
18	Active	SENOKOT S if pt receiving opioids or if constipated	AT BEDTIME	ROUTINE		06/12 21:00	Indefinite
		Dose: 2 TABLET					
		Route: PO					
19	Started	HYDROXYZINE HCL [ATARAX] for itching	Q6H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 25 MG					
		Route: PO					
20	Started	TRAZODONE [DESYREL] for insomnia	QHS PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 25-50 MG					
		Route: PO					
21	Started	ONDANSETRON INJ [ZOFTRAN] for nausea	Q8H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 8 MG					
		Route: IV					
22	Started	GLYCOPYRROLATE INJ [ROBINUL] for secretions	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 0.2-0.4 MG					
		Route: IV					
23	Started	HALOPERIDOL INJ [HALDOL] for delirium, agitation, restlessness, nausea; may give po or iv	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 1-2 MG					
		Route: IV					
24	Started	HALOPERIDOL [HALDOL] for delirium, agitation, restlessness, nausea; may give iv or po	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 1-2 MG					
		Route: PO					
26	Started	POLYETHYLENE GLYCOL ORAL POWDER DAILY PRN [MIRALAX] for constipation if no bm in 48 hrs	DAILY PRN	ROUTINE		06/12 17:31	Indefinite
		Dose: 17 G					
		Route: PO					
28	started	BISACODYL SUPPOSITORY [DULCOLAX] PRN AS DIR for constipation if no bm in 72 hrs and no results with miralax	PRN AS DIR	ROUTINE		06/12 17:31	Indefinite
		Dose: 10 MG					
		Route: PR					
29	Started	MORPHINE INJ for pain or dyspnea	Q2H PRN	ROUTINE	7 Days	06/12 17:31	06/19 17:30
		Dose: 2 - 4 MG					
		Route: IV					
30	Started	OXYCODONE IMMEDIATE RELEASE for pain or dyspnea; dispense elixir	Q1H PRN	ROUTINE	7 Days	06/12 17:31	06/19 17:30
		Dose: 5 - 10 MG					
		Route: PO					

CONTINUED

PRINTED BY: DB30588

Page 2

PERM

DATE

7/18/2013

FARR, WILLIAM G
SPARTANBURG REGION

Order Confirmation Report - FARR, WILLIAM G

DEPT: HOS ROOM: HH09-A MR: 000478684

Ordered by: MD SNIPES, GARRETT E

Authenticated by: MD SNIPES, GARRETT E - 06/12/12 17:38

Order mode: Direct - Session Id:18952682

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
31	Started	LORAZEPAM INJ [ATIVAN] for anxiety; may give po or iv Dose: 0.5 - 1 MG Route: IV	Q4H PRN	ROUTINE		06/12 17:32	Indefinite
32	Started	LORAZEPAM [ATIVAN] for anxiety; may give iv or po Dose: 0.5 MG Route: PO	Q4H PRN	ROUTINE		06/12 17:32	Indefinite
33	Active	DEXAMETHASONE NA PHOSPHATE INJ Dose: 4 MG Route: IV	Q12H	ROUTINE		06/12 21:00	Indefinite
34	Active	OXYCODONE IMMEDIATE RELEASE To control dyspnea. Patient may refuse. Hold if sedated Dose: 5 MG Route: PO	Q8H	ROUTINE	7 Days	06/12 23:59	06/19 23:58
38	Started	MONTelukAST SODIUM [SINGULAIR] Dose: 10 MG Route: PO Primary Instructions: give at 1800 daily	QPM 18	NOW		06/12 17:35	Indefinite
39	Active	THEOPHYLLINE 24 HOUR [THEO-24] Dose: 300 MG Route: PO	DAILY	NEXT SCH		06/13 09:00	Indefinite
41	Active	CITALOPRAM [CELEXA] Dose: 20 MG Route: PO	DAILY	NEXT SCH		06/13 09:00	Indefinite

2001-10
6/13/12
DD

Aut. Det
6/12 1945

FARR, WILLIAM G
SPARTANBURG REGIO.

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPES, GARRETT E
Authenticated by: MD SNIPES, GARRETT E - 06/13/12 12:38
Order mode: Direct - Session Id:18958773

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy		

FMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
29	Modified	MORPHINE INJ	Q30MINPRN	ROUTINE	7 Days	06/13 12:36	06/19 17:30
v3		ASSESS LAXATIVE NEED -FOR PAIN. FOR "PRN" MEDICATIONS, -DOCUMENT PRE/POST PAIN -SCORES, IF APPLICABLE -- -- -FOR PAIN OR DYSPNEA					
		Dose: 2-4 MG					
		Route: IV					
31	Modified	LORAZEPAM INJ [ATIVAN]	Q2H PRN	ROUTINE	30 Days	06/13 12:38	07/12 17:31
v3		FOR ANXIETY, AGITATION, AND-OR -NERVOUSNESS. -FOR NAUSEA AND-OR VOMITING. -- -- -FOR ANXIETY; MAY GIVE PO OR IV					
		Dose: 0.5-1 MG					
		Route: IV					
48	Started	ALBUTEROL - IPRATROPIUM SOLN INH Q4HPRNRESP		ROUTINE	3 Days	06/13 12:35	06/16 12:34
		Dyspnea/wheezing					
		Dose: 3 ML					
		Route: INHALATN					

RT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
49	Active	HHN	PRN	ROUTINE	3 Days	06/13 18:00	06/16 17:59
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: Dyspnea/wheezing; med: duonebaero 3 ml Q4H PRN x3 days					

240
6/14/12
f. Stachey
0120

FARR, WILLIAM G
SPARTANBURG, SC 29106

Order Confirmation Report - FARR, WILLIAM G
 DEPT: HOS ROOM: HH09-A MR: 000478684
 Ordered by: MD SNIPES, GARRETT E
 Authenticated by: MD SNIPES, GARRETT E - 06/14/12 10:21
 Order mode: Direct - Session Id:18966245

ALLERGY

Charted	Allergy name	Type	Reaction	Severity	Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy			

FMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
33	Modified	DEXAMETHASONE NA PHOSPHATE INJ	Q12H	ROUTINE		06/14 10:13	Indefinite
v3		GENERIC SUBSTITUTION FOR DECADRON. -MONITOR PATIENT FOR HYPERGLYCEMIA - ~ ~					
		Dose: 8 MG					
		Route: IV					
34	D/C'd	OXYCODONE IMMEDIATE RELEASE	Q8H	ROUTINE	7 Days	06/12 23:59	06/19 16:01
v3		ASSESS LAXATIVE NEED -FOR PAIN. FOR "PRN" MEDICATIONS, -DOCUMENT PRE/POST PAIN					
		-SCORES, IF APPLICABLE -TO CONTROL DYSPNEA. PATIENT MAY REFUSE. ~ HOLD IF SEDATED					
		Dose: 5 MG					
		Route: PO					
44	D/C'd	ALBUTEROL - IPRATROPIUM SOLN INH Q4H W/A		ROUTINE		06/13 06:00	
v2		USE FOR ALBUTEROL AND ATROVENT.					
		Dose: 3 ML					
		Route: INHALATN					
53	Active	OXYCODONE ER [OXYCONTIN]	Q12H	NEXT SCH	7 Days	06/14 21:00	06/21 20:59
		Dose: 10 MG					
		Route: PO					
54	Started	ALBUTEROL 0.5% SOLN IN 2.5 ML NS Q4H RESP		ROUTINE		06/14 10:17	Indefinite
		Dose: 2.5 MG					
		Route: INHALATN					
56	Started	ALBUTEROL 0.5% SOLN IN 2.5 ML NS Q4HPRNRESP		ROUTINE	3 Days	06/14 10:18	06/17 10:17
		Wheezing					
		Dose: 2.5 MG					
		Route: INHALATN					
58	Active	DIAZEPAM [VALIUM]	Q12H	ROUTINE		06/14 21:00	Indefinite
		To control anxiety associated with dyspnea. Patient may refuse. Hold if sedated.					
		Dose: 2.5 MG					
		Route: PO					
59	Started	BUDESONIDE INHALATION SUSP (JET NEB ONLY)	Q12H RESP	ROUTINE		06/14 10:21	Indefinite
		Dose: 0.5 MG					
		Route: INHALATN					

RT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
55	Started	HHN	Q4H	ROUTINE		06/14 10:17	Indefinite
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: ; med: albuterolaero 2.5 mg Q4H					
57	Active	HHN	PRN	ROUTINE	3 Days	06/14 18:00	06/17 17:59
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: Wheezing; med: albuterolaero 2.5 mg Q4H PRN x3 days					
60	Started	HHN	Q12H	ROUTINE		06/14 10:21	Indefinite
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: ; med: budesonideaero 0.5 mg Q12H					

240
6/13/12
0010
Brockman

D. Brenda Ireland
6/14/12 @ 1400

Longman
6/14/12
1102

LAST PAGE

PRINTED BY: DB30588

Page 1

PERM

DATE

7/18/2013

FARR, WILLIAM G
SPARTANBURG REGION

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPES, GARRETT E
Authenticated by: MD SNIPES, GARRETT E - 06/14/12 10:25
Order mode: Direct - Session Id:18966360

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy		

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
61	Active	GUAIFENESIN LA	Q12H	NEXT SCH		06/14 21:00	Indefinite
		Dose: 600 MG					
		Route: PO					

Dr. Jackson PO
6/14/12 @ 1400

240
6/13/12
0010
Spackler

K. B. Jackson
1/62
6/14/12



SPARTANBURG
Regional Healthcare System

☐ SRMC

☐ SHRC

☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME
DATE 06/14/12

Diagnosis:

✓ BIPAP - 14/7
MDD USE PRN REVERO

BY PRN 12/12
FIO2 50%
DS

TAXED

24hr
6/13/12
0010

Obanda Jackson MD
6/14/12 @ 1400

W. Snipes
6/14/12
1103

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:



REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

W. Snipes

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

W. Snipes

Patient Label

1216401412 000 478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E

Date/Time

06/14/12



1106 (Rev. 01)



SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height: Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME 2430
DATE 6/14/12

Diagnosis:

D/C Albuterol Scheduled $\frac{1}{2}$ PRN
Xopenex 0.63mg every 4 hours scheduled $\frac{1}{2}$ every 4 hrs PRN

Handwritten: 7/15/12 0930
EXPIRED

Handwritten: 2/10 ✓
Stackley
6/15/12
0010

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

Handwritten: Dr. Garrett Snipes

Handwritten: Stackley

REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

Handwritten: Dr. Garrett Snipes

PHYSICIAN SIGNATURE

Handwritten Signature

Date/Time

Handwritten: 06/15/12

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

Patient Label

1216401412 000-478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E





SPARTANBURG

Regional Healthcare System

☐ SRMC☐ SHRC☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME 0330
DATE 6/15/12

Diagnosis:

*Medication Renewal**Morphine Conc 5-10 mg every 2 hrs PRN*

FAXED

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

Dr. Garrett Snipes

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Garrett Snipes

Patient Label

1216401412 000-478684 06/12/12
FARR, WILLIAM G
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E

Date/Time

06/15/12

1106 (Rev. 09-10)





SPARTANBURG
Regional Healthcare System

☐ SRMC

☐ SHRC

☐ VH

PROGRESS NOTES

DATE/TIME	NOTES
06/12/12	Admit Note - 1st & Discharge
	69yo man with chronic left pulmonary due to -
	(1) ET COPD
	(2) S/P Bilateral resection (3) Lung
	(3) Probable, blood, lymphatic ch N/A ch 4 (N/A) PPS-307
	PLAN: (1) for management
	(2) Cont low burden med intervention
	(3) Home to home nursing if able
	(4) GOC disc on, partly "I want to be comfortable"
	Correct

1216401412 00 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E



1080 (Rev

Physician Progress Note

SPARTANBURG REGIONAL HOSPICE HOME

Date: 06/12/12 Time: _____

S: _____

INTERMITTENTLY VERY DYSPNEIC.
THIS MORNING RESPONSIBLY COMFORTABLE
BUT WORK - USING NECESSARY MUSCLES
OR VENTILATION.

Breakthrough doses:

Activity: BA Intake: POWO: Physical exam: Vital signs 200-110-16-138/82 ☐ UnremarkableGeneral: No distress / comfortable ~~mod distress~~ ~~severe distress~~Mental status: Alert ~~lethargic~~ ~~obtunded~~ ~~agitated~~ /SAS

HEENT: MMs moist/dry

Neck: JVD

Lungs: CTA / diminished (rales) wheez / upper airway congestionCardiac: RRR / tachycardic irregularAbd: Soft / distended / tender / BS pres/absExtremities: Edema

Neuro: _____

Other: _____

A: Assessment I/P: Plans

Hospice diagnosis SEVERE CHD / CHRONIC HEART FAILUREOther * PULMONARY HYPERTENSION

* DYSPNEA : INTERMITTENT
EXERCISE

→ ADDITIONAL / PROLIFERATION OF DYSPNEA
TRIA BIRM

☒ Family counseling: SON BRIAN / BROTHERPPS: 20 Prognosis: POOR TO POOR WRI - FURTHER DETERIORATIONReason for GIP (if applicable): ☐ Symptom management. What symptoms/how?:DYSPNEA☐ Other: _____Disposition: ☒ Active management ☐ Possible D/C if stabilizes ☐ Planning dischargeSignature: Garrett W
☐ Garrett Snipes, MD ☐ Brian Bell, MD
☐ Robert Houston, MD ☐ Sam Gacha, MD

1216401412 000-478684 06/12/12
 FARR, WILLIAM G M 69Y
 ADM: SNIPES, GARRETT E
 REF: SNIPES, GARRETT E



Physician Progress Note

SPARTANBURG REGIONAL HOSPICE HOME

Date: 06/18/12 Time: 12 PM

S: _____

INITIALLY BETTER NO DYSPNOEA AND
THEN BECAME PROFOUNDLY
DYSPNOEIC P STANDING

Breakthrough doses: _____

Activity: _____

Intake: _____

O: Physical exam: Vital signs 97.7 - 128 - 30 - 128/64 ☐ UnremarkableGeneral: No distress / comfortable / mod distress / severe distressMental status: Alert / lethargic / obtunded / agitated / SASANXIETY / CYANOSISHEENT: MMs moist/dryNeck: JVDLungs: CTA / diminished / rales / wheeze / upper airway congestionCardiac: RRR / tachycardia / irregularAbd: Soft / distended / tender / BS pres/absExtremities: Edema

Neuro: _____

Other: _____

A: Assessment

Hospice diagnosis

Other

//P: Plans

A/C NEW FAILURE D/C COPD /
LUNG INFECTION /
INTERSTITIAL PNEUMONIA
VS. CA

- REVERS EXacerbation of DYSPNOEA PAIN
→ PRN OXYGEN, LORAZEPAM, MORPHINE OR
RELIEVE PR.

☒ Family counseling:UPDATE TO FAMILY BYRON, DANCERPPS: 30 - 20 Prognosis: ?DOX TO STOP WRT (COULD DIE IN
MY TIME)Reason for GIP (if applicable): ☐ Symptom management. What symptoms/how?: _____☐ Other: _____Disposition: ☐ Active management ☐ Possible D/C if stabilizes ☐ Planning discharge

Signature: _____

☐ Garrett Snipes, MD ☐ Brian Bell, MD☐ Robert Houston, MD ☐ Sam Gacha, MD

1216401412 000 478684 06/12/12

FARR, WILLIAM G

ADM: SNIPES, GARRETT E

REF: SNIPES, GARRETT E

M 69Y

REF: SNIPES, GARRETT E

REF: SNIPES, GARRETT E

REF: SNIPES, GARRETT E

REF: SNIPES, GARRETT E

REF: SNIPES, GARRETT E

REF: SNIPES, GARRETT E

Physician Progress Note

SPARTANBURG REGIONAL HOSPICE HOME

Date: 06/19/12 Time: _____

S: DYSPNOEA AT REST BUT NOT DISTRESSED
WEEK, GETTING WEAKER
EPISODE OF PROFOUND DYSPNOEA - 2
MUCON. PLUG

Breakthrough doses: YES - MORPHINE

Activity: BR Intake: + 1500

O: Physical exam: Vital signs 92.4 - 92.4 - 100/50 ☐ Unremarkable

General: No distress / comfortable / no distress / severe distress

Mental status: Alert / lethargic / obtunded / agitated / SAS

HEENT: MMS moist/dry

Neck: JVD

Lungs: CTA / diminished / rales / wheeze / upper airway congestion USING ALBUTEROL

Cardiac: RRR / tachycardic / irregular

Abd: Soft / distended / tender / BS pres/abs

Extremities: Edema

Neuro: _____

Other: _____

A: Assessment

Hospice diagnosis

Other

PP: Plans--

ES COPD

CHRONIC RECA. PAINING

PACB
HEAVY
LONG
CANCER

DYSPNOEA
CHRONICLY DECLINING

→ ① PS. DOES WANT CARE AT HT, DESPITE FAMILY
REPERATION

② AS TO MDD: - FOR TREATMENT WITH
WIDENED DYSPNOEA

☐ Family counseling: ③ PLAN BIVAP - OFFERING DNA TO LYNN

PPS: 200 Prognosis: 2 DAYS TO WEEK

Reason for GIP (if applicable): ☒ Symptom management. What symptoms/how?:

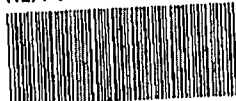
☐ Other:

Disposition: ☒ Active management ☐ Possible D/C if stabilizes ☐ Planning discharge

Signature: Garrett Snipes

☒ Garrett Snipes, MD ☐ Brian Bell, MD
☐ Robert Houston, MD ☐ Sam Gacha, MD

1216401412 000-478684 06/12/12
 FARR, WILLIAM G
 ADM: SNIPES, GARRETT E
 REF: SNIPES, GARRETT E





SPARTANBURG

Regional Healthcare System

☐ SRMC

☐ SHRC

☐ VH

PROGRESS NOTES

DATE/TIME	NOTES
06/16/12 11:10	S: SOB (+) wearing O₂ maximizer Q: VS stable Afebrile CW: hN2d Chest: Ratch (+) crackles (+) Ad B (+) Soft. A/P (1) ESCOPD (2) Chronic resp failure Plan: Wife @ bedside / w family. By RN family has been difficult to deal. PPS 10-20% Denies pain <i>[Signature]</i> SBACH, MD
06/17/12	D/K Summary dictated 1259443 <i>[Signature]</i> SNIPES, MD

Pa

1216401412 000-478684 06/12/12
 FARR, WILLIAM G
 ADM: SNIPES, GARRETT E M 69Y
 REF: SNIPES, GARRETT E



1080 (Rev. 1)

atient: FARR, WILLIAM G Address: 1032 JONESVILLE LOCKHART
DOB: [REDACTED] Fin Class: COMMERCIAL INSUR UNION
ex: MALE Ins. Plan: COMM/MGD CARE F/C CI, HE, MG, RHSC, 29379
S#: [REDACTED] Guarantor: SELF Phone #: (864) 251-0531

-5 Adm Date: 06/12/12 Adm Source: 4 TRANS FR/A HOSPIT Acct. #: 1216401412
dm Time: 15:17 Adm Type: 2 URGENT Unit. #: 000478684
is Date: 06/16/12 Trans From: Pt. Type: INPATIENT
Dis Time: 17:00 Service: INTERNAL MEDICINE Trans To:
OS: 4 Dis Status: K-HOME HOSPICE Coder: KK
Submitting DR: SNIPES, GARRETT E Referring DR: SNIPES, GARRETT E
Attending DR: SNIPES, GARRETT E Discharge DR: GACHA, SAMUEL
PR Physician: Primary DR:

RG: 189 PULMONARY EDEMA & RESPIRATORY FAILURE
Admit Diagnosis: 518.84 ACUTE & CHRONC RESP FAIL
rincipal Diagnosis: 518.84 ACUTE & CHRONC RESP FAIL POA: Y
econdary Diagnoses/POA:
799.4 CACHEXIA/Y V10.05 HX OF COLONIC MALIGNANC/E
496 CHR AIRWAY OBSTRUCT NEC/Y 414.01 CRNRY ATHRSCL NATVE VSS/Y
162.9 MAL NEO BRONCH/LUNG NOS/Y V45.76 ACQ ABSENCE OF LUNG/E
412 OLD MYOCARDIAL INFARCT/E V87.41 HX ANTINEOPLASTIC CHEMO/E
515 POSTINFLAM PULM FIBROSIS/Y V66.7 ENCOUNTR PALLIATIVE CAR/E

Reason for Visit:

Principal Procedure: Date: Primary Surgeon:
econdary Procedures:
Consultants: Date: Specialty:

End of Report

DISCHARGE SUMMARY

PATIENT NAME: FARR, WILLIAM G

DOB: [REDACTED]

MEDICAL RECORD #: 478684

ACCOUNT NUMBER: 1216401412

ADMISSION DATE: 06/12/2012 DISCHARGE DATE: 06/16/2012

ATTENDING PHYSICIAN: SNIPES, GARRETT E

PALLIATIVE CARE MEDICINE DOCTOR

Dr. Snipes.

FINAL DISCHARGE DIAGNOSES

1. Acute-on-chronic respiratory failure.
2. End-stage chronic obstructive pulmonary disease.
3. Non-small cell lung carcinoma.
4. History of colon cancer.
5. Coronary artery disease with history of non-Q-wave myocardial infarction.

FINAL DISCHARGE HOME MEDICATIONS

1. Proventil 180 mcg 2 puffs inhalation every 2 hours as needed.
2. Citalopram 20 mg daily.
3. Diazepam 2.5 mg every 12 hours.
4. Mucinex 600 mg every 12 hours.
5. Singulair 10 mg daily.
6. Avelox 400 mg for 4 more days.
7. Nicotine patch 21 mg topically once a day.
8. Oxycodone 10 mg every 12 hours.
9. Protonix 40 mg daily.
10. Senokot 8.6 mg 2 tablets p.o. daily.
11. Theophylline 24 hours 300 mg daily.
12. Lorazepam 0.5 mg IV every 2 hours as needed.
13. Morphine sulfate 2 mg to 4 mg IV every 30 minutes as needed.
14. Lorazepam 0.5 mg every 4 hours as needed.
15. Combivent inhaler 2 puffs every 4 hours.
16. Beclovent inhaler 2 puffs every 4 hours.
17. Prednisone 40 mg daily.

BRIEF HISTORY OF PRESENT ILLNESS

This is a 69-year-old Caucasian man who was admitted to the hospice on 06/12/2012. He had an extensive past medical history of COPD with acute-on-chronic respiratory failure, had been getting progressively worse. He also had a stage II non-small cell lung carcinoma with right middle and lower lobectomies, who stopped chemoradiation after 5 cycles due to toxicity. He has been very cachectic and dyspneic even at rest. The patient has been discharged to the hospice and also admitted to Spartanburg Regional Medical Center after family had been calling 911. The patient has been managed as an outpatient by Dr. Littlefield. The patient was finally transferred to hospice home for symptom management.

HOSPICE HOUSE MANAGEMENT

The patient was managed with symptom management in usual fashion with small doses of opiates and supplement with short-acting opiates if needed. Extend our management for

end-stage COPD and bronchodilators and steroids.. Continue course of Avelox. PPA score 30%. Life expectancy is ill-defined at this point, but in the range of weeks to months in the outpatient. The patient was discharged on 06/16/2012. The patient was transferred to a hospice care of South Carolina.

DISPOSITION

Discharge home with hospice care.

DICTATED BY: SAMUEL GACHA, MD

DICTATED FOR:

D:06/17/2012 11:53:17

T:06/17/2012 12:58:57 /rv

1259443/1099480

cc:SNIPES, GARRETT E, Admitting Physician

Authenticated by Samuel Gacha, MD. On 06/18/2012 09:16:17 PM

HOSPICE CERTIFICATION OF TERMINAL ILLNESS

This is to certify that the beneficiary, named below, is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

1. Provider's Name, Address: Spartanburg Regional Hospice 120 Heywood Ave Suite 300 Spartanburg, SC 293021211 8645603900		2. Attending Physician's Name and Address: Mehta, Sharmila Pravin MD 380 Serpentine Drive Suite 200 Spartanburg, SC 29303 864-560-7050	
3. Hospice Physician's Name and Address: Snipes, Garrett E MD 686 Jeff Davis Drive Spartanburg, SC 29303 864 560 5620		4. Patient's Name: Farr, William G 5. Current Election Date: 06/07/2012 6. Benefit Period/Date Range: 1 From: 06/07/2012 To: 09/04/2012	
7. Start of Care Date: 06/07/2012	8. Medical Record No.: 03570052-00038224	9. Date of Birth: [REDACTED]	10. Sex: X M F
11. ICD-9-CM 1629	Terminal Diagnosis BRONCHUS/LUNG CA NOS	Date 053112 E	
12. Attending Physician Verbal Certification Received By and Date: Chalk, Miranda D 06/07/2012		13. Hospice Physician Verbal Certification Received By and Date: Chalk, Miranda D 06/07/2012	
14. Brief Narrative Statement: (Review the individual's clinical circumstances and synthesize the medical information, including the clinical findings from the face-to-face encounter, to provide clinical justification for certification or recertification to hospice services, including an explanation of why the clinical findings support a life expectancy of 6 months or less.) Narrative composed by Hospice Physician 69 yo. Marked wt loss. Declining PS (PPS 60%). Recent hosp admit for dyspnea due to pneumonia, but this continues to be a major symptom despite treatment of infection. Small cell lung cancer is the malignancy. Attestation Statement: By signing this certification, the Hospice Physician, named below, confirms that he/she composed the narrative based on his/her review of the patient's medical record or his/her examination of the patient.			
15. Attending Physician's Signature and Date: Mehta, Sharmila Pravin MD Mehta, Sharmila Pravin MD 06/25/12 03:51 PM Document Signed Electronically		16. Hospice Physician's Signature and Date: Snipes, Garrett E MD Snipes, Garrett E MD 06/12/12 06:54 AM Document Signed Electronically	

17. Document Author's Signature and Date:

Chalk, Miranda D RN 06/07/12

18. Date Provider Received Signed CTI:

06/25/2012

By Organization, By Entry User

Customer: Farr, William G - 03570052
Admit ID: 00038224
SRHS/SRMC/SRHC/SRHO
CHALMI - Chalk, Miranda

Customer: Farr, William G - 03570052
Organization: SRHS/SRMC/SRHC/SRHO
Type: AN--Admission Note - General
Author: Chalk, Miranda D
Subject: Admission Note - General
Note: S. Hospice Admission Visit

Admit ID: 00038224

Entered: 6/7/2012 4:28:17PM by: Chalk, Miranda
Completed: 6/7/2012 4:28:16PM by: Chalk, Miranda

DNR-NMV WT: 121 WT 3months ago 142 approx. Ht 5'4"

DOB [REDACTED] SOC 06/7/2012 Episode# 38224

B. 69 year old male admitted to Hospice with probable extension of previously diagnosed small cell lung CA. pt was pt was admitted to SRMC on 5.31.12 for increased SOB and possible PNA. pt has over the last 2 months been worked up for possible extension of previously diagnosed small cell lung Ca. pt had 2 biopsies by dr. cruz which were negative and then a surgical biopsy by dr. nguyen which was positive per pt dtr. pt was treated with antibiotic during hospital stay with no improvement per dtr. pt dyspnea has worsen since surgical biopsy...pt reports that prior to hospital stay he was working in yard and did not need oxygen. pt now needs oxygen with oxyimizer. PMH: Hx of colon Ca 14 yrs ago with cholestomy, small cell lung ca 2 yrs ago with right middle and upper lobectomy, COPD, HTN, hypokalemia and hyperlipidemia.

PPS 60 percent.

A. On arrival sn was met at the door by pt wife Deloris who has not spoken in 9 yrs due to severe depression. patient sitting in living room when sn arrived. Pt is alert and oriented x 3 but does report being forgetful at times. Pt report severe sob with exertion and while at rest at times. Lungs absent in right upper and middle lobes and decreased in lower right lobe and left lobes. abdomen soft and nontender...Last BM yesterday...active bowel sounds....sn instructed cg on stool softners and laxative and the results of pain meds on the GI system....pt report wt loss of more than 20lbs in the last 2 months. pt report that his eating and appetite is getting better but appetite is still poor. No edema noted on assessment.. pt denies bladder incontinence....pt has cholestomy from previous colon resection due to colon ca. pt denies pain during visit and reports that he rarely has pain and OTC meds help when he does. pt states that bathing has become very difficult due to pt is not able to stand without becoming severely sob. sn contacted QHM and requested delivery of shower chair and wheeled walker to help pt with sob on exertion...Crystal with QHM states delivery today. medication reviewed and reconciled. sn contacted dr. snipes and dr. mehta regarding POC and admission. dr. mehta will be attending and okayed order for comfort kit. Sn activated Hospicript card and covered medications profiled confirmation # 3400250

R.SN 1wk1 then 3wk12
MSW referral
PCT 2wk 12
Chaplain TBD
Volenteer declined



1. Patient's HI Claim No.: [REDACTED]		2. Start Of Care Date: 06/07/2012		3A. Certification Period: From: 06/07/2012 To: 09/04/2012		3B. Current Election Date: 06/07/2012	
3C. Current Benefit Period/Range: 1 From: 06/07/2012 To: 09/04/2012				4. Medical Record No.: 03570052-00038224		5. CCN: 421500	
6. Patient's Name and Address: Farr, William G 1032 Jonesville Lockhart Hwy UNION, SC 29379 864-251-0531				7. Provider's Name, Address and Telephone Number: Spartanburg Regional Hospice 120 Heywood Ave Suite 300 Spartanburg, SC 293021211 8645603900			
8. Date of Birth: 07/06/1942		9. Sex: X M F		10. Medications: Dose/Frequency/Route (N)ew (C)hanged Coverage:			
11. ICD-9-CM 1629	Terminal Diagnosis BRONCHUS/LUNG CA NOS	Date 053112 E		KLOR-CON M20 20 mEq TAB ER PRT (N) 2 ORAL 2 times daily			
12. ICD-9-CM 9396	Surgical Procedure OXYGEN ENRICHMENT NE	Date 060612		moxifloxacin 400mg tablet (N) 1 ORAL Daily			
13. ICD-9-CM 49121 4019 2768 2724	Other Pertinent Diagnoses OCB W EXACERBATION HYPERTENSION NOS HYPOKALCEMIA HYPERLIPIDEMIA NEC &	Date 053112 E 053112 E 053112 E 053112 E		NORCO 10 mg-325 mg TABLET (N) 1-2 ORAL Every 4 hours as needed (See Addendum)			
14. DME and Supplies: shower chair				15. Safety Measures: 1 - Established emergency/civil (See Addendum)			
16. Nutritional Req.: 1 - As tolerated 2 - No				17. Allergies: No Known Allergies			
18A. Functional Limitations: 6 - Endurance (See Addendum)				18B. Level of Activity: 3 - Chair (See Addendum)			
19. Mental/Emotional Status: 1 - Alert - (See Addendum)							
20. DNR Information : (Date Executed - Ordering Physician - Description) 06/07/2012 - Mehta, Sharmila Pravin MD - Do Not Resuscitate. Nurse May (See Addendum)							
21. Orders for Discipline and Treatment (Specify Amount/Frequency/Duration): CH 1 Day 1 Chaplain eval for services AIDE 2 Week 12							
22. Plans: Problems: (See Addendum)							
23. Nurse's Signature and Date of Verbal SOC Where Applicable: Chalk, Miranda D RN 06/06/12						24. Date Provider Received Signed POC: 06/19/2012	
Certification Statement: I certify/recertify that this patient is under my care, and to the best of my medical knowledge given the data available, has a life expectancy of six (6) months or less if the terminal illness runs its normal course. The focus of the care is on comfort and palliation rather than cure. I authorize the hospice care as outlined above.							
25. Attending Physician's Name and Address: Mehta, Sharmila Pravin MD 380 Serpentine Drive Suite 200 Spartanburg, SC 29303 864-560-7050				26. Hospice Physician's Name and Address: Snipes, Garrett E MD 686 Jeff Davis Drive Spartanburg, SC 29303 864 560 5620			
27. Attending Physician's Signature and Date Signed: Mehta, Sharmila Pravin MD 06/19/12 09:40 AM Document Signed Electronically				28. Hospice Physician's Signature and Date Signed: Snipes, Garrett E MD 06/10/12 10:52 AM Document Signed Electronically			
29. Interdisciplinary Signatures and Date Signed:							

Patient's HI Claim No. [REDACTED]	2. Start Of Care Date 06/07/2012	3. Certification Period From: 06/07/2012 To: 09/04/2012	4. Medical Record No. 03570052-00038224	5. CCN 421500
Patient's Name arr, William G		7. Provider Name Spartanburg Regional Hospice		

o. Item No.	
	OMEPRazole 20 mg TABLET DR (N) 1 ORAL 2. times daily; Coverage: Patient SIMVASTATIN 40 mg TABLET (N) 1 ORAL Bedtime; Coverage: Patient TRIAMTERENE W/HCTZ 37.5-25MG TABLET (N) 1 ORAL Daily; Coverage: Patient AMBIEN 10 mg TABLET (N) 1 ORAL Bedtime; Coverage: Provider PROAIR HFA 90 mcg HFA AER AD (N) 2 puffs INHALATION As needed; Coverage: Provider PROVENTIL 90 mcg AER REFILL (N) 2 puffs INHALATION Every 6 hours as needed; Coverage: Provider PREDNISONE 20 mg TABLET (N) 1 ORAL 3 times daily; Coverage: Provider ATIVAN 1 mg TABLET (N) 1-2 ORAL Every 4 hours as needed; Coverage: Provider ROXANOL 20 mg/mL SOLUTION (N) 0.25-0.5 ORAL Every 2 to 3 hours as needed; Coverage: Provider
15	disaster plan 2 - Established response plan 3 - Implement a fall prevention program (e.g. remove throw rugs/ teach safe use of assist/ safety devices) 4 - Teach proper/ safe use of medications 5 - Teach oxygen therapy safety precautions 6 - Teach operations/use of DME 7 - Teach appropriate cleaning of equipment 8 - Teach standard precautions (e.g. hand washing/safe disposal of contaminated sharps and supplies) 9 - Teach proper waste management skills
18A	7 - Ambulation A - Dyspnea w/ minimal exertion
8	bound 2 - Mainly Assisted A - Assistance of one or more persons
--	Oriented to Person Place Time 4 - Forgetful 6 - Lethargic
20	Verify Death in Home.

9. Signature of Physician <u>Mehta, Sharmila Pravin MD</u> Mehta, Sharmila Pravin MD Document Signed Electronically	10. Date 06/19/12 09:40 AM
11. Optional Name/Signature of Nurse/Therapist <u>Chalk, Miranda D RN</u>	12. Date 06/06/12
Addendum	Page 2 of 3

1. Patient's HI Claim No.	2. Start Of Care Date 06/07/2012	3. Certification Period From: 06/07/2012 To: 09/04/2012	4. Medical Record No. 03570052-00038224	5. CCN 421500
6. Patient's Name Farr, William G		7. Provider Name Spartanburg Regional Hospice		
8. Item No.				
21	Home Health aide to provide personal care MSS 1 Day 1 MSW eval for services SN 1 Day 1 RN eval for services SN 1 Week 1; 3 Week 12 SN visits prn x 8 for complications or change in condition Insert foley 14 or 16 fr 5 to 10 ml prn for comfort or incontinence. May irrigate catheter with 60 to 180 ml of normal saline prn for drainage complications not to exceed 3x in 24 hour period May teach caregiver to irrigate catheter May apply condom cath prn Male pts only. Cath In and Out prn for residual and if greater than 500ml leave foley in place Suction prn for increase congestion Instruct caregiver Dietary supplements prn decreased oral intake. Supplies As needed to support care and comfort. Mouth swabs toothettes diapers linen savers no rinse shampoo moisture barrier cream moisturizing cream DME As needed for decline in condition Hospital bed Category I mattress overlay prn comfort and or skin breakdown prevention. Wheelchair Quad cane BSC Standard or rolling walker Bedside table Shower seat Manual pt lift Trapeze bar Suction machine. May apply initial hydrocolloid, transparent or foam dressing prn for skin breakdown and call physician for further orders. May cleanse wound with wound cleanser or soap and water as needed prior to applying dressing. May secure foam dressing with hypafix. May apply ice pack to axilla for temp greater than 101 not relieved by meds May give fleets or SS enema prn constipation. May check for fecal impaction prn and disimpact prn signs and symptoms of impaction Initiate HHA services as indicated by need MSW referral Chaplain referral Volunteer prn Child bereavement services prn Homemaker service prn CWON consult prn Therapy evaluation prn Massage Therapy as needed for comfort I authorize the Hospice RN to be my agent for phone and verbal orders for my Hospice patient. May admit to Hospice Home as needed for General Inpatient or Respite Care Hospice Medical Director will assume care while the patient is in the Hospice Home			
22	EXPECTED OUTCOMES Plans: Verbalizes correct medication/supplement schedule or has written schedule for reference. Verbalizes hospice protocol. Verbalizes plan of care and hospice services. Verbalizes how and when to contact hospice staff. Patient verbalizes/demonstrates effective level of pain and/or symptom control Verbalizes primary concern and personal goals for care. Verbalizes measures to ensure personal safety. Pt/Cg verbalizes disease progression: s/sx dying, potential for skin breakdown, urinary incontinence, decreased desire/ability to eat/drink and alternative treatment measures to increase comfort.			
9. Signature of Physician			10. Date	
 <u>Mehta, Sharmila Pravin MD</u> Mehta, Sharmila Pravin MD Document Signed Electronically			06/19/12 09:40 AM	
11. Optional Name/Signature of Nurse/Therapist			12. Date	
<u>Chalk, Miranda D RN</u>			06/06/12	
Addendum			Page 3 of 3	

Admission Note Report

By Organization, By Entry User

Customer: Farr, William G - 03570052
Admit ID: 00038224
RHS/SRMC/SRHC/SRHO
CHALMI - Chalk, Miranda

Customer: Farr, William G - 03570052
Organization: SRHS/SRMC/SRHC/SRHO
Type: HA--Health Aide MobileCare/Telephony Note
Author: Chalk, Miranda D
Subject: HA - HOART - Telephony Care Plan Created
Note:

Entered: 6/7/2012 5:34:11PM by: Chalk, Miranda
Completed: 6/7/2012 5:34:11PM by: Chalk, Miranda
Admit ID: 00038224

TelID	Res?	Dt/Tm?	Task Desc
130	N	N	DNR - Call Nurse
135	N	N	Oxygen - May Not remove during bath
138	N	N	Shower with bench
142	N	N	Brush/Shampoo hair as requested
144	N	N	Mouth Care as requested
145	N	N	Apply lotion as requested
146	N	N	Apply skin barrier as requested
152	N	N	Empty ostomy bag
147	N	N	Toileting assist - Bedpan/Urinal
153	N	N	Shave/assist with shave as requested
154	N	N	Change clothing
156	N	N	Backrub as requested
158	N	N	Assist ambulation with Device

1612139507

HOSPICE PLAN OF CARE

1. Patient's EI Claim No.: [REDACTED] 2. Start Of Care Date: 06/07/2012 3A. Certification Period: From: 06/07/2012 To: 09/04/2012 3B. Current Election Date: 06/07/2012

3C. Benefit Period/Data Range: 1 From: 06/07/2012 To: 09/04/2012 4. Medical Record No.: 03570032-00038224 5. CCN: 421500

6. Patient's Name and Address:

Farr, William G
1032 Jonessville Lockhart Hwy
Union, SC 29379
864-251-0531

7. Provider's Name, Address and Telephone Number:

Spartanburg Regional Hospice
120 Haywood Ave
Suite 100
Spartanburg, SC 293021211
8645603900

8. Date of Birth: 07/06/1942

9. Sex: X M F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged Coverage:

ICD-9-CM	Terminal Diagnosis	Date
1629	BRONCHUS/LUNG CA NOS	053112 E
12 ICD-9-CM	Surgical Procedure	Date
9396	OXYGEN ENRICHMENT NE	060612
13 ICD-9-CM	Other Pertinent Diagnoses	Date
49121	OCR W EXACERBATION	053112 E
4019	HYPERTENSION NOS	053112 E
2768	HYPOPOTAEMIA	053112 E
2724	HYPERLIPIDEMIA NEC	053112 E

KLOR-COM M20 20 mg TAB ER PRT (N)
2 ORAL 2 times daily

moxifloxacin 400mg tablet (N)
1 ORAL Daily

NORCO 10 mg-325 mg TABLET (N)
1-2 ORAL Every 4 hours as needed

OMEPRazole 20 mg TABLET OR (N)
1 ORAL 2 times daily; Coverage: Patient

SIMVASTATIN 40 mg TABLET (N)
1 ORAL Bedtime; Coverage: Patient

TRIAMTERENE w/BCTE 37.5-25MG TABLET (N)
1 ORAL Daily; Coverage: Patient

AMBIEN 10 mg TABLET (N)
1 ORAL Bedtime; Coverage: Provider

PROAIR HFA 90 mcg HFA AER AD (N)
2 puffs INHALATION As needed; Coverage: Provider

PROVENTIL 90 mcg AER RESPIL (N)
2 puffs INHALATION Every 6 hours as needed;
Coverage: Provider

PREDNISONE 20 mg TABLET (N)
1 ORAL 3 times daily; Coverage: Provider

ATIVAN 1 mg TABLET (N)
1-2 ORAL Every 4 hours as needed; Coverage:
Provider

ROXANOL 20 mg/mL SOLUTION (N)
0.25-0.5 ORAL Every 2 to 3 hours as needed;
Coverage: Provider

14. DME and Supplies:

shower chair

15. Safety Measures:

1 - Established emergency/civil disaster plan 2 -
Established response plan 3 - Implement a fall
prevention program (e.g. remove throw rugs/ teach
safe use of assist/ safety devices) 4 - Teach
proper/ safe use of medications 5 - Teach oxygen
therapy safety precautions 6 - Teach
operations/use of DME 7 - Teach appropriate
cleaning of equipment 8 - Teach standard
precautions (e.g. hand washing/safe disposal of
contaminated sharps and supplies) 9 - Teach proper
waste management skills

16. Nutritional Requirements:

1 - As tolerated 2 - No

18.A. Functional Limitations:

6 - Endurance 7 - Ambulation A - Dyspnea w/ minimal
exertion

19. Mental/Emotional Status:

1 - Alert - Oriented to Person Place Time 4 - Forgetful 6 - Lethargic

17. Allergies:

No Known Allergies

18.B. Level of Activity:

3 - Chair bound 2 - Mainly Assisted A - Assistance
of one or more persons

Farr, William G

Cert. Dates: 060712

To: 090412

Plan of Care Page: 1 of 3

20. DMR Information: (Date Executed - Ordering Physician - Description)

06/07/2012 - Mahta, Sharmila Pravin MD - Do Not Resuscitate, Nurse May Verify Death in Home.

21. Orders for Discipline and Treatment (Specify Amount/Frequency/Duration):

CN 1 Day 1
Chaplain eval for servicesAIDE 2 Week 12
Home Health aide to provide personal careMSS 1 Day 1
MSW eval for servicesSN 1 Day 1
RN eval for services

SN 1 Week 1; 3 Week 12

SN visits prn x 9 for complications or change in condition
 Insert Foley 14 or 16 fr 5 to 10 ml prn for comfort or incontinence. May irrigate catheter with 60 to 160 ml of normal saline prn for drainage complications not to exceed 3x in 24 hour period May teach caregiver to irrigate catheter
 May apply condom cath prn Male pts only.
 Cath In and Out prn for residual and if greater than 500ml leave Foley in place
 Suction prn for increase congestion Instruct caregiver
 Dietary supplements prn decreased oral intake.
 Supplies As needed to support care and comfort. Mouth swabs toothettes diapers linen savers no rinse shampoo moisture barrier cream moisturizing cream
 DME As needed for decline in condition Hospital bed
 Category I mattress overlay prn comfort and or skin breakdown prevention. Wheelchair Quad cane B&C Standard or rolling walker
 Bedside table Shower seat
 Manual pt lift Trapesa bar Suction machine.
 May apply initial hydrocolloid, transparent or foam dressing prn for skin breakdown and call physician for further orders. May cleanse wound with wound cleanser or soap and water as needed prior to applying dressing. May secure foam dressing with hypafix.
 May apply ice pack to axilla for temp greater than 101 not relieved by meds
 May give fleets or 88 enema prn constipation. May check for fecal impaction prn and disimpact prn signs and symptoms of impaction
 Initiate RHA services as indicated by need
 MSW referral
 Chaplain referral
 Volunteer prn
 Child bereavement services prn
 Homemaker service prn
 CWCN consult prn
 Therapy evaluation prn
 Massage Therapy as needed for comfort
 I authorize the Hospice RN to be my agent for phone and verbal orders for my Hospice patient.
 May admit to Hospice Home as needed for General Inpatient or Respite Care
 Hospice Medical Director will assume care while the patient is in the Hospice Home

MSW referral
Chaplain referralVolunteer prn
Child bereavement services prn
Homemaker service prn
CWCN consult prn
Therapy evaluation prn

Massage Therapy as needed for comfort

I authorize the Hospice RN to be my agent for phone and verbal orders for my Hospice patient.

May admit to Hospice Home as needed for General Inpatient or Respite Care

Hospice Medical Director will assume care while the patient is in the Hospice Home

22. Plans:

Problems:
EXPECTED OUTCOMES

Plans:

Verbalizes current medication/supplement schedule or has written schedule for reference.

Verbalizes hospice protocol.

Verbalizes plan of care and hospice services.

Verbalizes how and when to contact hospice staff.

Patient verbalizes/demonstrates effective level of pain and/or symptom control

Verbalizes primary concern and personal goals for care.

Verbalizes measures to ensure personal safety.

pt/Cg verbalizes disease progression, A/OX dying, potential for skin breakdown, urinary incontinence, decreased desire/ability to eat/drink and alternative treatment measures to increase comfort.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

Chalk, Miranda D RN

06/06/2012

24. Date Provider Received Signed POC:

06/10/2012

Certification Statement:

I certify/re-certify that this patient is under my care, and to the best of my medical knowledge given the data available, has a life expectancy of six (6) months or less if the terminal illness runs its normal course. The focus of the care is on comfort and palliation rather than cure. I authorize the hospice care as outlined above.

25. Attending Physician's Name and Address:

Mahta, Sharmila Pravin MD
 380 Serpentine Drive
 Suite 200
 Spartanburg, SC 29303
 864-560-7050

27. Attending Physician's Signature and Date Signed:

Mahta, Sharmila Pravin MD

26. Hospice Physician's Name and Address:

Snipes, Garrett E MD
 686 Jeff Davis Drive
 Spartanburg, SC 29303
 864 560 5620

28. Hospice Physician's Signature and Date Signed:

Snipes, Garrett E MD

06/10/2012

Farr, William G

Cert. Dates: 060712

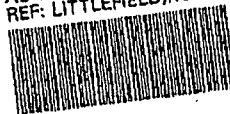
Tel: 090412

Plan of Care

Page: 2 of 3

29. Interdisciplinary Signatures and Date Signed:

1216200102 000478684 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



Farr, William G

Cert. Dates: 060712

To: 090412

Plan of Care

Page: 3 of 3



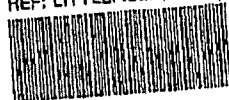
1612133506

HOSPICE CERTIFICATION OF TERMINAL ILLNESS

This is to certify that the beneficiary, named below, is terminally ill with a life expectancy of six months or less if the terminal illness runs its normal course.

1. Provider's Name, Address: Spartanburg Regional Hospice 120 Heywood Ave Suite 300 Spartanburg, SC 293021211 8645603900		2. Attending Physician's Name and Address: Mehta, Sharmila Pravin MD 380 Serpentine Drive Suite 200 Spartanburg, SC 29303 864-560-7050	
3. Hospice Physician's Name and Address: Snipes, Garrett E MD 686 Jeff Davis Drive Spartanburg, SC 29303 864 560 5620		4. Patient's Name: Farr, William G	
7. Start of Care Date: 06/07/2012		5. Current Election Date: 06/07/2012	
8. Medical Record No.: 03570052-00038224		6. Benefit Period/Date Range: 1 From: 06/07/2012 To: 09/04/2012	
11. ICD-9-CM 1629		9. Date of Birth: [REDACTED]	
Terminal Diagnosis BRONCHUS/LUNG CA NOS		10. Sex: X M F	
Date 053112 E			
12. Attending Physician Verbal Certification Received By and Date: Chalk, Miranda D RN 06/07/2012		13. Hospice Physician Verbal Certification Received By and Date: Chalk, Miranda D RN 06/07/2012	
14. Brief Narrative Statement: (Review the individual's clinical circumstances and synthesize the medical information, including the clinical findings from the face-to-face encounter, to provide clinical justification for certification or recertification to hospice services, including an explanation of why the clinical findings support a life expectancy of 6 months or less.) Narrative composed by Hospice Physician			

1216200102 000-478684 06/10/12
FARR, WILLIAM G M 69Y
ADM: LITTLEFIELD, RONALD
REF: LITTLEFIELD, RONALD



Attestation Statement:

By signing this certification, the Hospice Physician, named below, confirms that he/she composed the narrative based on his/her review of the patient's medical record or his/her examination of the patient.

15. Attending Physician's Signature and Date: Mehta, Sharmila Pravin MD		16. Hospice Physician's Signature and Date: Snipes, Garrett E MD	
17. Document Author's Signature and Date: Chalk, Miranda D RN 06/07/2012		18. Date Provider Received Signed CTI:	

Farr, William G

Benefit Period: 1 From: 06/07/2012 To: 09/04/2012

Hospice CTI Page 1 of 1

Patient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1216200102

Page 4 of 6



Spartanburg Regional HOSPICE

HOSPICE INPATIENT ADMISSION SHEET

☐ Please use the following Insurance Plan

☒ 870610 Hospice House only

☐ SRMC Hospice

☐ Other _____

☐ Please indicate the type of Hospice admission: 6/12/12

Date

Ashleigh Putt, RN
Hospice Authorization Signature

☐ Respite V60.5 (five days maximum stay)

☒ Pain and Symptom V66.7

☐ Condition Unrelated to the terminal diagnosis. Authorization is given to bill using the "07" code.

☐ Please complete the following and fax this form to the Admitting Office at 560-6005 once a hospital bed has been assigned:

☐ Patient name: William Farr

☐ Patient SS#: [REDACTED]

☐ Patient DOB: [REDACTED]

#9

☐ Admitting Physician: Garrett Snipes

☐ Admitting Diagnosis: V66.7

☐ Admission Date: 6/12/12

1216401412 000478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E





SPARTANBURG

Regional Healthcare System

☐ SRMC ☐ SHRC ☐ VH

Spartanburg Regional Hospice Home

Admission Report

1430

 Signature of Staff member taking report: Ashleigh Rutledge RN Date: 6/12/12
☒ Current ☐ New Regional Hospice patient ☐ Other agency

 Patient coming from: ☐ Home ☒ Hospital ☐ Facility 50

 Report given by: BRUCE, RN Contact number: 65757

 Pt. Name: William Farr Diagnosis: NSCLCA Age: 69

 Family contact name and number: Brian Farr 415-1662-son (POA)

 Allergies: NKA

 Ht.: 65" Wt.: 54.6 Kg Recent PPD: ☐ Yes ☒ No If yes, provide documentation

 Reason for Admission: Symptom management

 Goal of Admission: home hospice

Pain Rating:

 Patient Pain Goal: Ø problem

Current reported pain (0-10 scale): _____ Location: _____

Interventions tried: _____

 Medications given and time of last dose: Morphine / Ativan

L1330

Nausea/Vomiting:

☐ Yes ☒ No Interventions tried: _____

Medications given and time of last dose: _____

Dyspnea:

☐ None ☐ Mild ☒ Moderate ☐ Severe O2: 15L Lung Sounds: _____

 Interventions tried: non-rebreather

Medications given and time of last dose: _____

State of Consciousness:

 A&O x 3 ☐ Confused ☒ Lethargic ☐ Unresponsive ☐ Anxiety/Restlessness ☐ Other _____

Medications given and time of last dose: _____

Intake:

☐ NPO ☐ Clear Liquids ☐ Full Liquids ☐ Soft ☒ General Diet

Safety:

☐ Abuse/Neglect (Actual/Potential Risks or History): Ø

 Signature A Rutledge RN

 Date 6/12/12

Patient Label

 1216401412 000-478684 06/12/12
 FARR, WILLIAM G M 69Y
 ADM: SNIPES, GARRETT E
 REF: SNIPES, GARRETT E


1815-N (04-08) Page 1 of

IV/SQ Access:

☒ Yes ☐ No Type: PAC Location: (P) SC Placement Date: _____
Date last Flushed: _____

Elimination:

☒ Continent ☐ Incontinent ☐ Foley ☐ Depends
Date of Last BM: _____ ☐ Constipation ☐ Diarrhea ☐ Other

Interventions tried: _____

Medications given and time of last dose: Colostomy - colon resection E colon CA

Infection:

Type of infection: Ø Location: _____ Isolation needs: _____
Medications given and time of last dose: _____

Edema:

☐ Yes ☒ No Location: _____

Interventions tried: _____

Medications given and time of last dose: _____

Skin Integrity:

Describe: intact

Wound care needs: _____

☐ Wound Vac - If yes, discuss discontinuing prior to admission

Activity: ☐ Independent ☒ Bedrest ☐ Chair ☐ W/C ☐ Walker ☐ Cane ☐ Hoyer

☐ Orthopedic devices - unable to accommodate traction

Safety: ☐ Recent Fall Date: Ø Injuries: _____

Fingersticks: ☐ Yes ☒ No Frequency: _____ Insulin: _____

Amount: _____ Last dose given at: _____

Comments:

Littlefield

Feb. Lung CA (P) 4, M lobectomy

Nicotine Patch => still wants cigarette

APitt/G.RN
Signature

6/12/12
Date

Patient Label

1216401412 000-478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E



1815-N (04-08) Page 2 of 2

Please review, sign, and return to:

Orders For:

Spartanburg Regional Hospice
120 Heywood Ave
Suite 300
Spartanburg, SC 293021211

Farr, William G

MR #: 03570052

Episode ID: 00038224

Location:

Mehta, Sharmila Pravin MD
** No Address Specified

NPI: 1447371281



Order # 1612133508

Begin Date: 06/07/2012

Taken Date:

Entered Date: 06/07/2012 05:31 PM

New order for 06/07/2012

ROXANOL 20 mg/mL SOLUTION

0.25-0.5 ORAL Every 2 to 3 hours as needed

Coverage: Provider

Coverage: Provider

Order
Employee Chalk, Miranda D

Date 06/07/12

Order(s)

Physician

 Sharmila Pravin Mehta MD

Mehta, Sharmila Pravin MD

Document Signed Electronically

06/25/12 03:48 PM

Entry Date: 06/07/2012

Please review, sign, and return to:

Orders For:

Spartanburg Regional Hospice
120 Heywood Ave
Suite 300
Spartanburg, SC 293021211

Farr, William G

MR #: 03570052

Episode ID: 00038224

Location:

Mehta, Sharmila Pravin MD
380 Serpentine Drive
Suite 200
Spartanburg, SC 29303
NPI: 1447371281



Order # 1631113114

Begin Date: 06/11/2012

For Order: CH 1 Month 3, 4 As Needed 3

Taken Date:

The chaplain will provide spiritual support 1 x a month
and up 4 PRN visits.

Entered Date: 06/11/2012 01:32 PM

Discontinue Date: 06/16/2012 02:00 PM

Order _____ Date 06/11/12
Employee Jordan, Gary W Chaplain

Order(s)

Physician

 Sharmila Pravin Mehta MD

Mehta, Sharmila Pravin MD

Document Signed Electronically

06/25/12 03:48 PM

Entry Date: 06/11/2012

FARR, WILLIAM G
SPARTANBURG REGIONAL

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: Unit Secre BIGELOW, KENDRA R
Entered by: US BIGELOW, KENDRA R - 06/12/12 15:33
Order mode: Written - Session Id:18951514

ALLERGY					
Charted	Allergy name	Type	Reaction	Severity	Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy			

HEODEPT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
1	Started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Primary malignant neoplasm of lung (162.9)	CONTIN	ROUTINE		06/12 15:32	Indefinite
2	Started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Adenocarcinoma of lung (162.9)	CONTIN	ROUTINE		06/12 15:32	Indefinite
3	Started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Dyspnea (786.09)	CONTIN	ROUTINE		06/12 15:32	Indefinite
4	Started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Dyspnea (786.09)	CONTIN	ROUTINE		06/10 15:32	Indefinite

NOU

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
6	Started	SEND TRAY NOW Enter Diet in Instruction Box INSTRUCTIONS (Enter diet): : mechssoftdiet	ONCE	ASAP	1 Time	06/12 15:33	06/12 15:33

NS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
5	Started	MECHANICAL (SOFT) DIET DIET MODIFIER #1: NO DIET MODIFIER DIET MODIFIER #2: NO DIET MODIFIER DIET MODIFIER #3: NO DIET MODIFIER	M	DINNER		06/12 15:33	

LAST PAGE

Page 1

PERM

Patient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1216401412

Page 1 of 7

FARR, WILLIAM G
SPARTANBURG REGIONAL

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPE, GARRETT E
Authenticated by: MD SNIPE, GARRETT E - 06/12/12 17:38
Order mode: Direct - Session Id:18952682

ALLERGY	Charted	Allergy name	Type	Reaction	Severity	Comment
	03/23 13:22	NKA (NEEDS REVIEW)	Drug Allergy			

AMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
7	Started	ADMIT TO ADMIT TO: HOSPICE HOME	ONCE	ROUTINE	1 Time	06/12 17:30	06/12 17:30

NS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
5	D/C'd	MECHANICAL (SOFT) DIET	M	DINNER		06/12 15:33	
v2		DIET MODIFIER #1: NO DIET MODIFIER					
		DIET MODIFIER #2: NO DIET MODIFIER					
		DIET MODIFIER #3: NO DIET MODIFIER					
25	Started	REGULAR DIET as tolerated	M	BREAKFAST		06/12 17:30	Indefinite
		DIET MODIFIER #1: NO DIET MODIFIER					
		DIET MODIFIER #2: NO DIET MODIFIER					
		DIET MODIFIER #3: NO DIET MODIFIER					

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
8	Started	VITAL SIGNS	PER ROUTINE	ROUTINE		06/12 17:30	Indefinite
9	Started	CODE STATUS: nurse may assess CODE STATUS CATEGORIES: Cat 3 - DNR	QS	ROUTINE		06/12 17:30	Indefinite
10	Started	IV ACCESS with INT or SQ line as needed for medication administration	PRN	ROUTINE		06/12 17:30	Indefinite
11	Started	NSG:O2 PER NASAL CANNULA , oxymizer or mask @ 2-5 L/min; titrate to comfort	QS	ROUTINE		06/12 17:30	Indefinite
12	Started	NSG:WOUND CARE ; nursing to evaluate and begin wound care as needed	PRN	ROUTINE		06/12 17:30	Indefinite
13	Started	FOLEY CATHETER #16 or #18 Fr. as needed for incontinence or retention Indication: Terminal-comfort care	PRN	ROUTINE		06/12 17:30	Indefinite
14	Started	MESSAGE TO NURSING: pt may have the following alternative treatments as desired: aromatherapy, massage therapy, music therapy	QS	ROUTINE		06/12 17:30	Indefinite
27	Started	NURSING: if no bm in 72 hrs, repeat miralax 17 grams, check for impaction and treat appropriately and give bisacodyl 10 mg suppository (see med orders)	PRN	ROUTINE		06/12 17:31	Indefinite
35	Started	MESSAGE TO NURSING: Fan blowing on his face please	ONCE	ROUTINE	1 Time	06/12 17:33	06/12 17:33
36	Started	MESSAGE TO NURSING: Offer massage therapy please	ONCE	ROUTINE	1 Time	06/12 17:34	06/12 17:34
37	Started	MESSAGE TO NURSING: Please review meds with family, and keep them informed of med changes. Thanks.	ONCE	ROUTINE	1 Time	06/12 17:34	06/12 17:34
40	Started	MESSAGE TO NURSING: Please dose prn medications judiciously to preserve alertness to the extent possible and still maintain comfort (goals of care issue). THANKS!!!!	ONCE	ROUTINE	1 Time	06/12 17:37	06/12 17:37

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
15	Started	ACETAMINOPHEN for pain or fever > 101 deg. F; may give per rectum instead Dose: 650 MG Route: PO	Q4H PRN	ROUTINE		06/12 17:30	Indefinite

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PERM

FARR, WILLIAM G
SPARTANBURG REGIONAL

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPE, GARRETT E
Authenticated by: MD SNIPE, GARRETT E - 06/12/12 17:38
Order mode: Direct - Session Id:18952682

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
16	Started	ACETAMINOPHEN for pain or fever > 101 deg. F; may give po instead	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 650 MG Route: PR					
17	Started	ARTIFICIAL TEARS EYE DROPS ; keep at bedside; family may administer as needed	PRN AS DIR	ROUTINE		06/12 17:30	Indefinite
		Dose: 1-2 DROP Route: SA EYE					
18	Active	SENOKOT S if pt receiving opioids or if constipated	AT BEDTIME	ROUTINE		06/12 21:00	Indefinite
		Dose: 2 TABLET Route: PO					
19	Started	HYDROXYZINE HCL [ATARAX] for itching	Q6H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 25 MG Route: PO					
20	Started	TRAZODONE [DESYREL] for insomnia	Q8H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 25-50 MG Route: PO					
21	Started	ONDANSETRON INJ [ZOFTRAN] for nausea	Q8H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 8 MG Route: IV					
22	Started	GLYCOPYRROLATE INJ [ROBINUL] for secretions	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 0.2-0.4 MG Route: IV					
23	Started	HALOPERIDOL INJ [HALDOL] for delirium, agitation, restlessness, nausea; may give po or iv	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 1-2 MG Route: IV					
24	Started	HALOPERIDOL [HALDOL] for delirium, agitation, restlessness, nausea; may give iv or po	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 1-2 MG Route: PO					
26	Started	POLYETHYLENE GLYCOL ORAL POWDER DAILY PRN [MIRALAX] for constipation if no bm in 48 hrs		ROUTINE		06/12 17:31	Indefinite
		Dose: 17 G Route: PO					
28	Started	BISACODYL SUPPOSITORY [DULCOLAX] PRN AS DIR for constipation if no bm in 72 hrs and no results with miralax		ROUTINE		06/12 17:31	Indefinite
		Dose: 10 MG Route: PR					
29	Started	MORPHINE INJ for pain or dyspnea	Q2H PRN	ROUTINE	7 Days	06/12 17:31	06/19 17:30
		Dose: 2 - 4 MG Route: IV					
30	Started	OXYCODONE IMMEDIATE RELEASE for pain or dyspnea; dispense elixir	Q1H PRN	ROUTINE	7 Days	06/12 17:31	06/19 17:30
		Dose: 5 - 10 MG Route: PO					

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PERM

tient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1216401412

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FARR, WILLIAM G
SPARTANBURG REGIONAL

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPES, GARRETT E
Authenticated by: MD SNIPES, GARRETT E - 06/13/12 12:38
Order mode: Direct - Session Id:18958773

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy		

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
29	Modified	MORPHINE INJ	Q30MINERN	ROUTINE	7 Days	06/13 12:36	06/19 17:30
v3		ASSESS LAXATIVE NEED -FOR PAIN. FOR "PRN" MEDICATIONS, -DOCUMENT PRE/POST PAIN -SCORES, IF APPLICABLE - - - -FOR PAIN OR DYSPNEA					
		Dose: 2-4 MG					
		Route: IV					
31	Modified	LORAZEPAM INJ [ATIVAN]	Q2H PRN	ROUTINE	30 Days	06/13 12:38	07/12 17:31
v3		FOR ANXIETY, AGITATION, AND-OR -NERVOUSNESS. -FOR NAUSEA AND-OR VOMITING. - - - -FOR ANXIETY; MAY GIVE PO OR IV					
		Dose: 0.5-1 MG					
		Route: IV					
48	Started	ALBUTEROL - IPRATROPIUM SOLN INH Q4HPRNRESP		ROUTINE	3 Days	06/13 12:35	06/16 12:34
		Dyspnea/wheezing					
		Dose: 3 ML					
		Route: INHALATN					

RT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
49	Active	HHN	PRN	ROUTINE	3 Days	06/13 18:00	06/16 17:59
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: Dyspnea/wheezing; med: duonebaero 3 ml Q4H PRN x3 days					

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PERM

atient:FARR, WILLIAM G

MRN:000478684

Encounter:1216401412

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FARR, WILLIAM G
SPARTANBURG REGIONAL

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPE, GARRETT E
Authenticated by: MD SNIPE, GARRETT E - 06/14/12 10:21
Order mode: Direct - Session Id: 18966245

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy		

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
33	Modified	DEXAMETHASONE NA PHOSPHATE INJ	Q12H	ROUTINE		06/14 10:13	Indefinite
v3		GENERIC SUBSTITUTION FOR DECADRON. -MONITOR PATIENT FOR HYPERGLYCEMIA - . -					
		Dose: 8 MG					
		Route: IV					
34	p/c'd	OXYCODONE IMMEDIATE RELEASE	Q8H	ROUTINE	7 Days	06/12 23:59	06/19 16:01
v3		ASSESS LAXATIVE NEED -FOR PAIN. FOR "PRN" MEDICATIONS, -DOCUMENT PRE/POST PAIN -SCORES, IF APPLICABLE -TO CONTROL DYSPNEA. PATIENT MAY REFUSE. ~ HOLD IF SEDATED					
		Dose: 5 MG					
		Route: PO					
44	p/c'd	ALBUTEROL - IPRATROPIUM SOLN INH 0.4H W/A		ROUTINE		06/13 06:00	
v2		USE FOR ALBUTEROL AND ATROVENT.					
		Dose: 3 ML					
		Route: INHALATN					
53	Active	OXYCODONE ER [OXYCONTIN]	Q12H	NEXT SCH	7 Days	06/14 21:00	06/21 20:59
		Dose: 10 MG					
		Route: PO					
54	Started	ALBUTEROL 0.5% SOLN IN 2.5 ML NS Q4H RESP		ROUTINE		06/14 10:17	Indefinite
		Dose: 2.5 MG					
		Route: INHALATN					
56	Started	ALBUTEROL 0.5% SOLN IN 2.5 ML NS Q4HPRNRESP		ROUTINE	3 Days	06/14 10:18	06/17 10:17
		Wheezing					
		Dose: 2.5 MG					
		Route: INHALATN					
58	Active	DIAZEPAM [VALIUM]	Q12H	ROUTINE		06/14 21:00	Indefinite
		To control anxiety associated with dyspnea. Patient may refuse. Hold if sedated.					
		Dose: 2.5 MG					
		Route: PO					
59	Started	BUDESONIDE INHALATION SUSP (JET NEB ONLY!)	Q12H RESP	ROUTINE		06/14 10:21	Indefinite
		Dose: 0.5 MG					
		Route: INHALATN					

RT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
55	Started	HHN	Q4H	ROUTINE		06/14 10:17	Indefinite
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: ; med: albuterolaero 2.5 mg Q4H					
57	Active	HHN	PRN	ROUTINE	3 Days	06/14 18:00	06/17 17:59
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: Wheezing; med: albuterolaero 2.5 mg Q4H PRN x3 days					
60	Started	HHN	Q12H	ROUTINE		06/14 10:21	Indefinite
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: ; med: budesonideaero 0.5 mg Q12H					

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PERM

FARR, WILLIAM G
SPARTANBURG REGIONAL

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPES, GARRETT E
Authenticated by: MD SNIPES, GARRETT E - 06/14/12 10:25
Order mode: Direct - Session Id: 18966380

ALLERGY					
Charted	Allergy name	Type	Reaction	Severity	Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy			

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
61	Active	GUAIFENESIN LA	Q12H	NEXT SCH		06/14 21:00	Indefinite
		Dose: 600 MG					
		Route: PO					

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PERM

atient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1216401412

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FARR, WILLIAM G
SPARTANBURG REGION

Order Confirmation Report - FARR, WILLIAM G
 DEPT: HOS ROOM: HH09-A MR: 000478684
 Ordered by: Unit Secre BIGELOW, KENDRA R
 Entered by: US BIGELOW, KENDRA R - 06/12/12 15:33
 Order mode: Written - Session Id:18951514

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22	NKA (NEEDS REVIEW)	Drug Allergy		

HEODEPT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
1	Started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Primary malignant neoplasm of lung (162.9)	CONTIN	ROUTINE		06/12 15:32	Indefinite
2	Started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Adenocarcinoma of lung (162.9)	CONTIN	ROUTINE		06/12 15:32	Indefinite
3	Started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Dyspnea (786.09)	CONTIN	ROUTINE		06/12 15:32	Indefinite
4	Started	DIAGNOSIS: Category: Medical Enter a diagnosis search (part of a name or an ICD9 code): Dyspnea (786.09)	CONTIN	ROUTINE		06/10 15:32	Indefinite

NOU

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
6	Started	SEND TRAY NOW Enter Diet in Instruction Box INSTRUCTIONS (Enter diet): : mechsoftdiet	ONCE	ASAP	1 Time	06/12 15:33	06/12 15:33

NS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
5	Started	MECHANICAL (SOFT) DIET DIET MODIFIER #1: NO DIET MODIFIER DIET MODIFIER #2: NO DIET MODIFIER DIET MODIFIER #3: NO DIET MODIFIER	M	DINNER		06/12 15:33	

2400
 6/13/12
 0702
 Haggins
 1552
 6/12/12

Handwritten signature and initials, possibly "Haggins" and "2400".

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PERM

FARR, WILLIAM G
SPARTANBURG REGIO.

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPE, GARRETT E
Authenticated by: MD SNIPE, GARRETT E - 06/12/12 17:38
Order mode: Direct - Session Id:18952682

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22	NKA (NEEDS REVIEW)	Drug Allergy		

AMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
7	Started	ADMIT TO ADMIT TO: HOSPICE HOME	ONCE	ROUTINE	1 Time	06/12 17:30	06/12 17:30

NS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
5	D/C'd	MECHANICAL (SOFT) DIET	M	DINNER		06/12 15:33	
v2		DIET MODIFIER #1: NO DIET MODIFIER					
		DIET MODIFIER #2: NO DIET MODIFIER					
		DIET MODIFIER #3: NO DIET MODIFIER					
25	Started	REGULAR DIET as tolerated	M	BREAKFAST		06/12 17:30	Indefinite
		DIET MODIFIER #1: NO DIET MODIFIER					
		DIET MODIFIER #2: NO DIET MODIFIER					
		DIET MODIFIER #3: NO DIET MODIFIER					

NSG

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
8	Started	VITAL SIGNS	PER ROUTINE	ROUTINE		06/12 17:30	Indefinite
9	Started	CODE STATUS: nurse may assess	QS	ROUTINE		06/12 17:30	Indefinite
		CODE STATUS CATEGORIES: Cat 3 - DNR					
10	Started	IV ACCESS with INT or SQ line as needed for medication administration	PRN	ROUTINE		06/12 17:30	Indefinite
11	Started	NSG:O2 PER NASAL CANNULA oxygenizer or mask @ 2-5 L/min; titrate to comfort	QS	ROUTINE		06/12 17:30	Indefinite
12	Started	NSG:WOUND CARE ; nursing to evaluate and begin wound care as needed	PRN	ROUTINE		06/12 17:30	Indefinite
13	Started	POLEY CATHETER #16 or #18 Fr. as needed for incontinence or retention	PRN	ROUTINE		06/12 17:30	Indefinite
		Indication: Terminal-comfort care.					
14	Started	MESSAGE TO NURSING: pt may have the following alternative treatments as desired: aromatherapy, massage therapy, music therapy	QS	ROUTINE		06/12 17:30	Indefinite
27	Started	NURSING: if no bm in 72 hrs, repeat miralax 17 grams, check for impaction and treat appropriately and give bisacodyl 10 mg suppository (see med orders)	PRN	ROUTINE		06/12 17:31	Indefinite
35	Started	MESSAGE TO NURSING: Fan blowing on his face please	ONCE	ROUTINE	1 Time	06/12 17:33	06/12 17:33
36	Started	MESSAGE TO NURSING: Offer massage therapy please	ONCE	ROUTINE	1 Time	06/12 17:34	06/12 17:34
37	Started	MESSAGE TO NURSING: Please review meds with family, and keep them informed of med changes. Thanks.	ONCE	ROUTINE	1 Time	06/12 17:34	06/12 17:34
40	Started	MESSAGE TO NURSING: Please dose prn medications judiciously to preserve alertness to the extent possible and still maintain comfort (goals of care issue). THANKS!!!!	ONCE	ROUTINE	1 Time	06/12 17:37	06/12 17:37

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
15	Started	ACETAMINOPHEN for pain or fever > 101 deg. F; may give per rectum instead	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
		Dose: 650 MG					
		Route: PO					

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PERM

FARR, WILLIAM G
SPARTANBURG REGION

Order Confirmation Report - FARR, WILLIAM G
 DEPT: HOS ROOM: HH09-A MR: 000478684
 Ordered by: MD SNIPES, GARRETT E
 Authenticated by: MD SNIPES, GARRETT E - 06/12/12 17:38
 Order mode: Direct - Session Id:18952682

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
16	Started	ACETAMINOPHEN for pain or fever > 101 deg. F; may give po instead Dose: 650 MG Route: PR	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
17	Started	ARTIFICIAL TEARS EYE DROPS ; keep at bedside; family may administer as needed Dose: 1-2 DROP Route: EA EYE	PRN AS DIR	ROUTINE		06/12 17:30	Indefinite
18	Active	SENOKOT S if pt receiving opioids or if constipated Dose: 2 TABLET Route: PO	AT BEDTIME	ROUTINE		06/12 21:00	Indefinite
19	Started	HYDROXYZINE HCL [ATARAX] for itching Dose: 25 MG Route: PO	Q6H PRN	ROUTINE		06/12 17:30	Indefinite
20	Started	TRAZODONE [DESYREL] for insomnia Dose: 25-50 MG Route: PO	QHS PRN	ROUTINE		06/12 17:30	Indefinite
21	Started	ONDANSETRON INJ [ZOFRAN] for nausea Dose: 8 MG Route: IV	Q8H PRN	ROUTINE		06/12 17:30	Indefinite
22	Started	GLYCOPYRROLATE INJ [ROBINUL] for secretions Dose: 0.2-0.4 MG Route: IV	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
23	Started	HALOPERIDOL INJ [HALDOL] for delirium, agitation, restlessness, nausea; may give po or iv Dose: 1-2 MG Route: IV	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
24	Started	HALOPERIDOL [HALDOL] for delirium, agitation, restlessness, nausea; may give iv or po Dose: 1-2 MG Route: PO	Q4H PRN	ROUTINE		06/12 17:30	Indefinite
26	Started	POLYETHYLENE GLYCOL ORAL POWDER DAILY PRN [MIRALAX] for constipation if no bm in 48 hrs Dose: 17 G Route: PO	DAILY PRN	ROUTINE		06/12 17:31	Indefinite
28	Started	BISACODYL SUPPOSITORY [DULCOLAX] PRN AS DIR for constipation if no bm in 72 hrs and no results with miralax Dose: 10 MG Route: PR	PRN AS DIR	ROUTINE		06/12 17:31	Indefinite
29	Started	MORPHINE INJ for pain or dyspnea Dose: 2 - 4 MG Route: IV	Q2H PRN	ROUTINE	7 Days	06/12 17:31	06/19 17:30
30	Started	OXYCODONE IMMEDIATE RELEASE for pain or dyspnea; dispense elixir Dose: 5 - 10 MG Route: PO	Q1H PRN	ROUTINE	7 Days	06/12 17:31	06/19 17:30

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PERM

FARR, WILLIAM G
SPARTANBURG REGIO

Order Confirmation Report - FARR, WILLIAM G
 DEPT: HOS ROOM: HH09-A MR: 000478684
 Ordered by: MD SNIPES, GARRETT E
 Authenticated by: MD SNIPES, GARRETT E - 06/12/12 17:38
 Order mode: Direct - Session Id:18952682

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
31	Started	LORAZEPAM INJ [ATIVAN] for anxiety; may give po or iv Dose: 0.5 - 1 MG Route: IV	Q4H PRN	ROUTINE		06/12 17:32	Indefinite
32	Started	LORAZEPAM [ATIVAN] for anxiety; may give iv or po Dose: 0.5 MG Route: PO	Q4H PRN	ROUTINE		06/12 17:32	Indefinite
33	Active	DEXAMETHASONE NA PHOSPHATE INJ Dose: 4 MG Route: IV	Q12H	ROUTINE		06/12 21:00	Indefinite
34	Active	OXYCODONE IMMEDIATE RELEASE To control dyspnea. Patient may refuse. Hold if sedated Dose: 5 MG Route: PO	Q8H	ROUTINE	7 Days	06/12 23:59	06/19 23:58
38	Started	MONTelukAST SODIUM [SINGULAIR] Dose: 10 MG Route: PO Primary Instructions: give at 1800 daily	QPM 18	NOW		06/12 17:35	Indefinite
39	Active	THEOPHYLLINE 24 HOUR [THEO-24] Dose: 300 MG Route: PO	DAILY	NEXT SCH		06/13 09:00	Indefinite
41	Active	CITALOPRAM [CELEXA] Dose: 20 MG Route: PO	DAILY	NEXT SCH		06/13 09:00	Indefinite

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PERM

Patient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1216401412

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FARR, WILLIAM G
SPARTANBURG REGIO.

Order Confirmation Report - FARR, WILLIAM G
 DEPT: HOS ROOM: HH09-A MR: 000478684
 Ordered by: MD SNIPES, GARRETT E
 Authenticated by: MD SNIPES, GARRETT E - 06/13/12 12:38
 Order mode: Direct - Session Id:18958773

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22	NKA (NEEDS REVIEW)	Drug Allergy		

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
29	Modified	MORPHINE INJ	Q30MINPRN	ROUTINE	7 Days	06/13 12:35	06/19 17:30
v3		ASSESS LAXATIVE NEED -FOR PAIN. FOR "PRN" MEDICATIONS, --DOCUMENT PRE/POST PAIN --SCORES, IF APPLICABLE --. -- -FOR PAIN OR DYSPNEA					
		Dose: 2-4 MG					
		Route: IV					
31	Modified	LORAZEPAM INJ [ATIVAN]	Q2H PRN	ROUTINE	30 Days	06/13 12:38	07/12 17:31
v3		FOR ANXIETY, AGITATION, AND-OR -NERVOUSNESS. -FOR NAUSEA AND-OR VOMITING. --. -- -FOR ANXIETY; MAY GIVE PO OR IV					
		Dose: 0.5-1 MG					
		Route: IV					
48	Started	ALBUTEROL - IPRATROPIUM SOLN INH Q4HPRNRESP		ROUTINE	3 Days	06/13 12:35	06/16 12:34
		Dyspnea/wheezing					
		Dose: 3 ML					
		Route: INHALATN					

RT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
49	Active	HBN	PRN	ROUTINE	3 Days	06/13 18:00	06/16 17:59
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: Dyspnea/wheezing; med: duonebaero 3 ml Q4H PRN x3 days					

240
6/14/12
f. Stachler
0120

LAST PAGE

Page 1 PERM

FARR, WILLIAM G
SPARTANBURG REGIO.

Order Confirmation Report - FARR, WILLIAM G
 DEPT: HOS ROOM: HH09-A MR: 000478684
 Ordered by: MD SNIPES, GARRETT E
 Authenticated by: MD SNIPES, GARRETT E - 06/14/12 10:21
 Order mode: Direct - Session Id:18966245

ALLERGY

Charted	Allergy name	Type	Reaction	Severity	Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy			

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop	
33	Modified	DEKAMETHASONE NA PHOSPHATE INJ	Q12H	ROUTINE		06/14 10:13	Indefinite	
v1		GENERIC SUBSTITUTION FOR DECADRON. ~MONITOR PATIENT FOR HYPERGLYCEMIA ~. ~						
		Dose: 8 MG						
		Route: IV						
34	D/C'd	OXYCODONE IMMEDIATE RELEASE	Q8H	ROUTINE	7 Days	05/12 23:59	06/19 16:01	
v3		ASSESS LAXATIVE NEED ~FOR PAIN. FOR "PRN" MEDICATIONS, ~DOCUMENT PRE/POST PAIN ~SCORES, IF APPLICABLE ~TO CONTROL DYSPNEA. PATIENT MAY REFUSE. ~ HOLD IF SEDATED						
		Dose: 5 MG						
		Route: PO						
44	D/C'd	ALBUTEROL - IPRATROPIUM SOLN INH Q4H W/A		ROUTINE		05/13 06:00		
v2		USE FOR ALBUTEROL AND ATROVENT.						
		Dose: 3 ML						
		Route: INHALATN						
53	Active	OXYCODONE ER (OXYCONTIN)	Q12H	NEXT SCH	7 Days	06/14 21:00	06/21 20:59	
		Dose: 10 MG						
		Route: PO						
54	Started	ALBUTEROL 0.5% SOLN IN 2.5 ML NS Q4H RESP		ROUTINE		06/14 10:17	Indefinite	
		Dose: 2.5 MG						
		Route: INHALATN						
56	Started	ALBUTEROL 0.5% SOLN IN 2.5 ML NS Q4HPRNRESP		ROUTINE	3 Days	06/14 10:18	06/17 10:17	
		Wheezing						
		Dose: 2.5 MG						
		Route: INHALATN						
58	Active	DIAZEPAM (VALIUM)	Q12H	ROUTINE		06/14 21:00	Indefinite	
		To control anxiety associated with dyspnea. Patient may refuse. Hold if sedated.						
		Dose: 2.5 MG						
		Route: PO						
59	Started	BUDESONIDE INHALATION SUSP (JET	Q12H RESP	ROUTINE		06/14 10:21	Indefinite	
		NEB ONLY!)						
		Dose: 0.5 MG						
		Route: INHALATN						

RT

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
55	Started	HEN	Q4H	ROUTINE		06/14 10:17	Indefinite
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: ; med: albuterolaero 2.5 mg Q4H					
57	Active	HEN	PRN	ROUTINE	3 Days	06/14 18:00	06/17 17:59
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: Wheezing; med: albuterolaero 2.5 mg Q4H PRN x3 days					
60	Started	HEN	Q12H	ROUTINE		06/14 10:21	Indefinite
		TRANSPORTATION METHOD: BEDSIDE/PORTABLE					
		ENTER ORDER UNDER INSTRUCTIONS					
		INSTRUCTIONS: ; med: budesonideaero 0.5 mg Q12H					

LAST PAGE

Page 1

PERM

tient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1216401412

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FARR, WILLIAM G
SPARTANBURG REGION

Order Confirmation Report - FARR, WILLIAM G
DEPT: HOS ROOM: HH09-A MR: 000478684
Ordered by: MD SNIPES, GARRETT E
Authenticated by: MD SNIPES, GARRETT E - 06/14/12 10:25
Order mode: Direct - Session Id:18966360

ALLERGY				
Charted	Allergy name	Type	Reaction	Severity Comment
03/23 13:22 NKA	(NEEDS REVIEW)	Drug Allergy		

PMS

Ord#	Action	Order Name	Freq	Priority	Duration	Start	Stop
61	Active	GUAIFENESIN LA	Q12H	NEXT SCH		06/14 21:00	Indefinite
		Dose: 600 MG					
		Route: PO					

Sharon Jackson RD
6/14/12 @ 1400

240
6/15/12
0010
Spokane

K. Bayless
1162
6/14/12

LAST PAGE

Page 1

PERM



SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height: Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME
DATE 06/14/12

Diagnosis:

✓ BIPAP - 14/7

MDD USE FAN REVERO

RX FAN 12/12

F102 50%
~~DS~~

INDEXED

242
6/13/12
0010

Shonda Jackson RD
6/14/12 @ 400

W/14/12
1103

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:



REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

W. G. FARR

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

W. G. FARR

Patient Label

1216401412 000-478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E

Date/Time

06/14/12

1108 (Rev. 01)





SPARTANBURG
Regional Healthcare System

☐ SRMC ☐ SHRC ☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height: Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED

PHYSICIANS ORDER FORM

TIME 2430
DATE 6/14/12

Diagnosis:

D/C Albuterol Scheduled $\frac{1}{2}$ PRN

Vopenex 0.63mg every 4 hours scheduled $\frac{1}{2}$ every 4 hrs PRN

Handwritten: 7/15/12 0930
Stamp: TAXI

Handwritten: 240
Stacking
6/15/12
0010

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:

Handwritten: Dr. Garrett Snipes

REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

Handwritten: Dr. Garrett Snipes

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Handwritten Signature: [Signature]

Patient Label

1216401412 000-478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E



Date/Time

Handwritten: 06/14/12

1106 (Rev. 09-1)



SPARTANBURG
Regional Healthcare System

☐ SRMC☐ SHRC☐ VH

Use Ball Point Pen and Press Firmly

REQUIRED FOR ADMISSION

Height:

Weight:

Allergies:

CHECK
OFF EACH
ORDER AS
TRANSCRIBED**PHYSICIANS ORDER FORM**TIME 0830
DATE 6/15/12

Diagnosis:

*Medication Renewal**Morphine Conc 5-10mg every 2 hrs PRN**24hr
Stocking
6/15/12
0830***EXPIRED**

TIME NOTED

TELEPHONE/VERBAL ORDER RECEIVED BY:



REMINDER: VERIFY & READ BACK

PHYSICIAN PRINTED NAME

Dr. Garrett Snipes

RECORD FINAL DIAGNOSIS ON THE FACE SHEET

PHYSICIAN SIGNATURE

Garrett Snipes

Patient Label

1216401412 000-478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E

Date/Time

06/15/12

1106 (Rev. 09-10)

atient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1216401412

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SOC

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

DOB: [REDACTED]

SOC: 06/07/2012

Spartanburg Regional Hospice

120 Heywood Ave

Suite 300

Spartanburg, SC 293021211

8645603900

Contains

Hospice SN Initial/Re-evaluation (V1)

Hospice IDG Careplan 3 Non-Visit

Hospice IDG Careplan 3 Nursing Admission

Date In: 6/7/2012 11:40:00AM

Date Out: 6/7/2012 1:20:00PM

Personnel: Chalk, Miranda D

Hospice SN Initial/Re-evaluation (V1)Clinical Record Items

Initial or Re-Evaluation	Initial Evaluation
Patient ID Number	00038224
Start of Care Date	06/07/2012
Date Assessment Completed	06/07/2012
Patient Name	Farr William G
Patient State	SC
Patient Zip Code	29379
Medicare Number	[REDACTED]
Patient Social Security Number	[REDACTED]
Patient Medicaid Number	NA - No Medicaid
Patient Date of Birth	[REDACTED]
Primary Referring Physician ID	1619935715
Discipline of Person Completing Assessment	1 - RN
Consent for treatment signed by:	06/07/2012 1 - Patient
Notice of Election	06/07/2012
Primary Diagnosis	MALIGNANT NEOPLASM OF BRONCHUS AND LUNG, UNSPECIFIED 1629
Secondary Diagnosis	OBSTRUCTIVE CHRONIC BRONCHITIS WITH (ACUTE) EXACERBATION 49121 UNSPECIFIED ESSENTIAL HYPERTENSION 4019 HYPOPOTASSEMIA 2768 OTHER AND UNSPECIFIED HYPERLIPIDEMIA

Created: 6/7/2012 12:21:00PM

Printed: 8/26/2013 11:10:06AM

Completed: 6/7/2012 5:19:00PM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Secondary Diagnosis

Knowledge/Understanding of Disease Process - Patient

Knowledge/Understanding of Disease Process - Note

2724

- 1 - Demonstrates knowledge/understanding of treatment plan
- 2 - Demonstrates knowledge/understanding of disease management
- 3 - Demonstrates knowledge/understanding of prognosis
- 4 - Demonstrates knowledge/understanding of DNR

S. Hospice Admission Visit

DNR-NMV WT: 121 WT 3months ago 142 approx. Ht 5'4"

DOB 7.6.42 SOC 06/7/2012 Episode# 38224

B. 69 year old male admitted to Hospice with probable extension of previously diagnosed small cell lung CA. pt was pt was admitted to SRMC on 5.31.12 for increased SOB and possible PNA. pt has over the last 2 months been worked up for possible extension of previously diagnosed small cell lung Ca. pt had 2 biopsies by dr. cruz which were negative and then a surgical biopsy by dr. nguygen which was positive per pt dtr. pt was treated with antibiotic during hospital stay with no improvement per dtr. pt dyspnea has worsen since surgical biopsy...pt reports that prior to hospital stay he was working in yard and did not need oxygen. pt now needs oxygen with oxyimizer. PMH: Hx of colon Ca 14 yrs ago with cholostomy, small cell lung ca 2 yrs ago with right middle and upper lobectomy, COPD, HTN, hypokalemia and hyperlipidemia.

PPS 60 percent.

3 - Five or more times

How many times has the patient been hospitalized in the past 6 months?

How many times has the patient visited the Emergency Room in the past 6 months?

Do you want cardiopulmonary resuscitation if your heart or lungs stop working?

Do you want to avoid hospitalization if your condition worsens?

Is patients terminal illness related to HIV?

Is the patients terminal illness related to ALS?

Dementia - Is the patients terminal diagnosis related to Dementia?

Is the patients terminal diagnosis related to Stroke and/or Coma?

Is the patients terminal diagnosis related to Renal Failure?

Is patients terminal diagnosis related to End Stage Cardiac Disease?

Is patients terminal diagnosis related to End Stage Pulmonary Disease?

Is patients terminal diagnosis related to End Stage Liver Disease?

Is the patients terminal illness related to Failure to Thrive?

Treatment/Therapy History

1 - One to two times

2 - No

2 - No

2 - No

2 - No

2 - No

2 - No

2 - No

2 - No

2 - No

2 - No

2 - No

1 - Biopsy

2 - Chemotherapy

3 - Radiation (Curative)

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Page 2 of 11



Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Estimated Time from Diagnosis to Hospice Care:
Progression of Current Illness Notes

Dec. 2010 per pt
S. Hospice Admission Visit

DNR-NMV WT: 121 WT 3months ago 142 approx. Ht 5'4"

DOB 7.6.42 SOC 06/7/2012 Episode# 38224

B. 69 year old male admitted to Hospice with probable extension of previously diagnosed small cell lung CA. pt was pt was admitted to SRMC on 5.31.12 for increased SOB and possible PNA. pt has over the last 2 months been worked up for possible extension of previously diagnosed small cell lung Ca. pt had 2 biopsies by dr. cruz which were negative and then a surgical biopsy by dr. nguygen which was positive per pt dtr. pt was treated with antibiotic during hospital stay with no improvement per dtr. pt dyspnea has worsen since surgical biopsy...pt reports that prior to hospital stay he was working in yard and did not need oxygen. pt now needs oxygen with oxyimizer. PMH: Hx of colon Ca 14 yrs ago with cholestomy, small cell lung ca 2 yrs ago with right middle and upper lobectomy, COPD, HTN, hypokalemia and hyperlipidemia.

PPS 60 percent.

1 - Patient owns home/residence

5 - Hospital/Skilled nursing facility

2 - Married

1 - Spouse/Significant other

No risk factors present

3 - Family/support feels overwhelmed

6 - Illness causes changes in lifestyle

10 - Denial of patient illness

11 - Concern over outcome of illness/fear of death

3 - Speech/Language

5 - Emotionally unstable

No signs of abuse/neglect

24 hours cg in home.

122

80

2 - Sitting

Left

107

1 - Regular

1 - Apical

18

1 - None

96.7

Living Arrangements/Supportive Care - Current

Living Arrangements/Supportive Care - Prior

Patient's Relationship Status

Relationship of Primary Caregiver

Risk Assessment

Caregiver Source of Stress

Does the Caregiver appear to have any limitations?

Abuse/Neglect

When patient becomes dependent and unable to meet her/his needs, pt agrees to:

Systolic Blood Pressure (1)

Diastolic Blood Pressure (1)

Blood Pressure taken in which Position (1)

Blood Pressure taken in which Arm (1)

Pulse (1)

Characteristic of Pulse (1)

Location Pulse was Taken (1)

Respirations

Oxygen Use

Temperature

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Temperature Degrees measured in	Fahrenheit
Location Temperature was Taken	1 - Oral
Is patient 18 years or older?	1 - Yes
Can patient self report?	1 - Yes
Are you uncomfortable because of pain?	2 - No
Pain Status	Patient denies pain at this time.
Cancer Specific Criteria	Progression from an earlier stage disease to metastasis disease with either A continued decline in spite of therapy
Physical baseline...weight and weight changes	pt current wt 121..pt wt 2months ago was 142lbs
Mental Status	1 - Alert - Oriented to
Mental Status Oriented to	Person
Mental Status Place	Place
Mental Status Time	Time
Mental Status	4 - Forgetful
	6 - Lethargic
Sleep/Rest - Quality	3 - Frequently interrupted/awakens frequently
Sleep/Rest - Use of medications/sleep aids	4 - More than once per night
Neurological Status	NO SIGNIFICANT FINDINGS
Sensory/Communication	NO SIGNIFICANT FINDINGS
Pts ability to express self:	1 - Expresses thoughts, feelings, needs w/o difficulty
Usual Weight	142
Current Weight	121
Appetite	fair
Diet/Nutritional Requirements	1 - As tolerated
Average Daily Intake	9-32 oz.
Tube Feeding	2 - No
Dental Function	3 - Dentures
If patient experienced significant non-intentional weight loss, is it expected/related to disease process:	1 - Yes
Does the patient/family have concerns in regard to the patients nutritional status?	2 - No
Has the patient made wishes known to withhold artificial nutrition or hydration?	2 - No
Is dietary consult needed? If yes, contact registered dietitian.	2 - No
Oral/Pharyngeal	NO SIGNIFICANT FINDINGS
GI/GU/Reproductive	NO SIGNIFICANT FINDINGS
Last Bowel Movement Date	06/06/2012
Stool softener or laxative required?	1 - Yes
GI/GU/Reproductive	NO SIGNIFICANT FINDINGS
Reproductive	Not Assessed
Sexuality/Physical Contact/Closeness	Deferred/Not Applicable

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Cardiovascular System	1 - Fatigue
	9 - Tachycardia
Peripheral pulses	No significant findings
Capillary refill	1 - Less than 3 seconds
Edema	None noted
Vascular Access Type	4 - Implanted Device (Port etc.)
Vascular Access Location	left subclavian
Vascular Access Site	No Significant Findings
Conditions Affecting Respiratory Status	1 - Dyspnea with activity
	2 - Dyspnea at rest
	3 - Orthopnea
Breath Sound Condition	Diminished
Location of Lung Sounds	RLL
	LUL
	LLL
Breath Sound Condition	Absent
Location of Lung Sounds	RUL
	RML
Productive Cough	1 - Yes
Color of Mucus	1 - Clear
Consistency of Mucus	1 - Thin
Amount of Mucus	1 - Small
Liver	NO SIGNIFICANT FINDINGS
ADL - ROM	Limited
	Fall risk
ADL - Bathing	Assist
	Needs Met
ADL - Groom/Dress	Assist
	Needs Met
ADL - Eating/Oral Care	Assist
	Needs Met
ADL - Ambulation	Assist
	Needs Met
ADL - Toileting	Assist
	Needs Met
Functional Limitations	6 - Endurance
	7 - Ambulation
	A - Dyspnea w/ minimal exertion
Current Level of Activity	3 - Chair bound

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Current Level of Activity	2 - Mainly Assisted
Fall Risk Consciousness/Mental Status	A - Assistance of one or more persons
Fall Risk Consciousness/Mental Status Score	0 - Alert - (oriented x 3) or Comatose
Fall Risk History of Falls	0
Fall Risk History of Falls Score	0 - No falls (in past 3 months)
Fall Risk Ambulation/Elimination Status	0
Fall Risk Ambulation/Elimination Status Score	0 - Ambulatory/continent
Fall Risk Vision	0
Fall Risk Vision Score	0 - Adequate (with or without glasses)
Fall Risk Gait/Balance	0
Fall Risk Gait/Balance Score	1 - Balance problem while standing
Fall Risk Systolic Blood Pressure	1 - Balance problem while walking
Fall Risk Systolic Blood Pressure Score	2
Fall Risk Medications	0 - No noted drop between lying and standing
Fall Risk Medications Score	0
Fall Risk Predisposing Diseases	2 - Takes 1-2 of these medications currently and/or w/in last 7 days
Fall Risk Predisposing Diseases Score	2
Fall Risk Total Score	0 - None present
Wheeled Walker (Assist Device)	0
Other [specify] / (Assist Device)	4
Assist Devices/HME	Needs
Skin Integrity	Needs
Braden Scale Sensory Perception	shower chair
Sensory Perception Score	Patient does not have integrity issues at this time.
Braden Scale Moisture	No impairment - Responds to verbal commands. Has no sensory deficit which would limit ability to feel or voice pain or discomfort.
Moisture Score	4
Braden Scale Activity	Rarely moist - Skin is usually dry; linen only requires changing at routine intervals.
Activity Score	4
Braden Scale Mobility	Walks occasionally - Walks occasionally during day but for very short distances, with or without assistance. Spends majority of each shift in bed or chair.
Mobility Score	3
Braden Scale Nutrition	Slightly limited - Makes frequent though slight changes in body or extremity position independently.
Nutrition Score	3
	Probably inadequate - Rarely eats complete meal and generally eats only about 1/2 of any food offered. Protein intake includes only 3 servings of meat or dairy products per day. Occasionally will take a dietary supplement, OR receives less than optimum
	2

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Braden Scale Friction and Shear

Potential problem - Moves feebly or requires minimum assistance. During a move, skin probably slides to some extent against sheets, chair, restraints, or other devices. Maintains relatively good position in chair or bed most of the time but occasionally

Friction and Shear Score

2

Braden Scale Total Score

18

Issues related to imminent death

No issues at present.

Status of Plans for Funeral/Final Arrangements:

1 - No plans initiated

Emotional Status

Mood/Affect stable and appropriate

Emotional Status - Caregiver

4 - Avoidant

6 - Depressed

22 - Withdrawn

Patient Coping Mechanisms

4 - Distancing

5 - Escape/Avoidance

Caregiver Coping Mechanisms

3 - Denial

Safety/Sanitation Issues:

1 - Bathroom lacks grab bars (toilet/tub/shower)

6 - Entry lacks needed ramp and/or rails

Environment (home) is suitable for care in home?

1 - Yes

Safety Measures

1 - Established emergency/civil disaster plan

2 - Established response plan

3 - Implement a fall prevention program (e.g. remove throw rugs/ teach safe use of assist/ safety devices)

4 - Teach proper/ safe use of medications

5 - Teach oxygen therapy safety precautions

6 - Teach operations/use of DME

7 - Teach appropriate cleaning of equipment

8 - Teach standard precautions (e.g. hand washing/safe disposal of contaminated sharps and supplies)

9 - Teach proper waste management skills

Factors Potentially Impairing Learning - Caregiver

2 - Language/Communication

Instructions/Materials Provided to Patient/Caregiver

1 - Patient Bill of Rights/Responsibilities

Discussed

Copy left in home

2 - State Hospice hot line number

Discussed

Copy left in home

3 - Explanation/Assignment of benefits

Discussed

Copy left in home

4 - Hospice service agreement

Discussed

Copy left in home

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Instructions/Materials Provided to Patient/Caregiver

5 - Hospice health schedule

Discussed

6 - Advance directives

Discussed

7 - Do Not Resuscitate

Discussed

8 - Agency Phone numbers

Discussed

Copy left in home

9 - Emergency response plan

Discussed

Copy left in home

10 - Fire/Evacuation response plan

Discussed

Copy left in home

11 - Confidentiality/Medical record access

Discussed

Copy left in home

Materials given to:

Agency phone numbers displayed in an easy-to-see areas near the phone?

Grief/Bereavement

1 - Patient

1 - Yes

2 - Complicated grief

4 - Other (specify)

cg with severe depression and sn concerned regarding coping.

1 - RN

3 - Social Worker

4 - Chaplain

5 - Medical Director

6 - Attending MD

7 - Hospice Admin.

8 - HHA

10 - Pt/Caregiver re: change in POC

Not Assessed on this visit

Grief/Bereavement Other

IDT Communication

Supervisory Visit

Created: 6/7/2012 12:21:00PM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Clinician DiagnosesResolvedDescription

Physical/symptom issues: pain, delirium, cognitive impairments, dyspnea, cough, wound, nausea, vomiting, anorexia, bladder incontinence, bowel incontinence, constipation, diarrhea, immobility, self-care deficit __

Psychosocial/emotional issues: agitation, anxiety, depression, stress, anticipatory grieving, denial, anger, ineffective coping, intimacy, self image, limited support system, substance abuse, mental illness __

Caregiver issues: anxiety, depression, anticipatory grieving, burden of care, limited support system, physical limitations, substance abuse, mental illness __

Functional/Safety issues: immobility, self-care deficit__

Spiritual issues: altered access to faith/spiritual community, alteration in spiritual practices, altered belief system, altered life's meaning, need for closure, spiritual distress __

Family/support issues: family conflict, communication, lack of resources, child/teen grief, role reversal, finances, inadequate housing __

OXYGEN Use/Safety

Palliative/Hospice Disease Management

PAIN MANAGEMENT

Symptom Management

Fall/Safety Risk Prevention

Nutrition - End of Life

Grouped Clinician Diagnosis: Not Associated**Interventions**

Intervention
Category:

NURSE CLINICAL SUMMARY

Identified: 06/07/2012

Achieved:

AchievedInterventionsPerformedVarVar TypeRsn CodeAct CodMove to
Next Visit
N

Enter a summary of the NURSE Visit in the NOTE BOX. Include items that may require follow up. Background required on Admission clinical summary.

Y

N

Created: 6/7/2012 12:21:00PM

Printed: 8/26/2013 11:10:06AM

Completed: 6/7/2012 5:19:00PM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Note: S. Hospice Admission Visit

DNR-NMV WT: 121 WT 3months ago 142 approx. Ht 5'4"

SOC 06/7/2012 Episode# 38224

B. 69 year old male admitted to Hospice with probable extension of previously diagnosed small cell lung CA. pt was admitted to SRMC on 5.31.12 for increased SOB and possible PNA. pt has over the last 2 months been worked up for possible extension of previously diagnosed small cell lung Ca. pt had 2 biopsies by dr. cruz which were negative and then a surgical biopsy by dr. nguyen which was positive per pt dtr. pt was treated with antibiotic during hospital stay with no improvement per dtr. pt dyspnea has worsen since surgical biopsy...pt reports that prior to hospital stay he was working in yard and did not need oxygen. pt now needs oxygen with oxyimixer. PMH: Hx of colon Ca 14 yrs ago with cholestomy, small cell lung ca 2 yrs ago with right middle and upper lobectomy, COPD, HTN, hypokalemia and hyperlipidemia.

PPS 60 percent.

A. On arrival sn was met at the door by pt wife Deloris who has not spoken in 9 yrs due to severe depression. patient sitting in living room when sn arrived. Pt is alert and oriented x 3 but does report being forgetful at times. Pt report severe sob with exertion and while at rest at times. Lungs absent in right upper and middle lobes and decreased in lower right lobe and left lobes. abdomen soft and nontender...Last BM yesterday...active bowel sounds...sn instructed cg on stool softners and laxative and the results of pain meds on the GI system....pt report wt loss of more than 20lbs in the last 2 months. pt report that his eating and appetite is getting better but appetite is still poor. No edema noted on assessment.. pt denies bladder incontinence....pt has cholestomy from previous colon resection due to colon ca. pt denies pain during visit and reports that he rarely has pain and OTC meds help when he does. pt states that bathing has become very difficult due to pt is not able to stand without becoming severely sob. sn contacted QHM and requested delivery of shower chair and wheeled walker to help pt with sob on exertion...Crystal with QHM states delivery today. medication reviewed and reconciled. sn contacted dr. snipes and dr. mehta regarding POC and admission: dr. mehta will be attending and okayed order for comfort kit. Sn activated Hospicript card and covered medications profiled confirmation # 3400250

R.SN 1wk1 then 3wk12

MSW referral

PCT 2wk 12

Chaplain TBD

Volunteer declined

Grouped Clinician Diagnosis: Palliative/Hospice Disease Management

Interventions

Intervention Category:	HOSPICE SERVICES	Identified: 06/07/2012	Achieved:					
	<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
		Provide Hospice Orientation Booklet; Instruct on Hospice notice of election, Advance directives, Service authorization, Rights and Responsibilities.	Y	N				N
		Instruct on Hospice protocol: verification of poor prognosis; dying at home; call Hospice, not 911; team problem-solving; caregiver involvement; infection control.	Y	N				N

Intervention Category:	DISEASE AND SYMPTOM	Identified: 06/07/2012	Achieved:					
	<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>

Created: 6/7/2012 12:21:00PM

Printed: 8/26/2013 11:10:06AM

Completed: 6/7/2012 5:19:00PM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Assess resuscitation status.	Y	N	N
Instruct on symptom management	Y	N	N
Instruct on disease progression	Y	N	N
Initiate order for DME/ medical supplies as needed.	Y	N	N

Grouped Clinician Diagnosis: Physical/symptom issues: pain, delirium, cognitive impairments, dyspnea, cough, wound, nausea, vomiting, anorexia, bladder incontinence, bowel incontinence, constipation, diarrhea, immobility, self-care deficit __

InterventionsIntervention
Category:**DISEASE AND SYMPTOM**

Identified: 06/07/2012 , Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Reconcile Medications	Y	N				N
	Evaluate medications for duplicate drug therapy, interactions, ineffective drug therapy, side effects and non-compliance.	Y	N				N
	Instruct on medication/supplement schedule	Y	N				N

Grouped Clinician Diagnosis: Psychosocial/emotional issues: agitation, anxiety, depression, stress, anticipatory grieving, denial, anger, ineffective coping, intimacy, self image, limited support system, substance abuse, mental illness __

InterventionsIntervention
Category:**PSYCHOSOCIAL/SPIRITUAL/CULTURAL**

Identified: 06/07/2012 , Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Develop plan of care/goals for care. Support involvement of pt/family in plan.	Y	N				N

Created: 6/7/2012 12:21:00PM
 Completed: 6/7/2012 5:19:00PM
 Author: Chalk, Miranda D

Printed: 8/26/2013 11:10:06AM

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routine visit

Customer: Farr, William G
Customer ID: 03570052
Admit ID: 00038224
DOB: [REDACTED]
SOC: 06/07/2012

Spartanburg Regional Hospice
120 Heywood Ave
Suite 300
Spartanburg, SC 293021211
8645603900

Contains
SRHS Hospice SN Routine
Hospice IDG Careplan 3 Non-Visit
Hospice IDG Careplan 3 Nursing Condition Progressing

Date In: 6/8/2012 9:43:00AM
Date Out: 6/8/2012 10:58:00AM
Personnel: Dunnaway, Alicia R RN

SRHS Hospice SN Routine

Clinical Record Items

Patient ID Number	00038224
Patient Name	Farr William G
Patient Date of Birth	[REDACTED]
Patient Social Security Number	[REDACTED]
Start of Care Date	06/07/2012
Discipline of Person Completing Assessment	1 - RN
Systolic Blood Pressure (1)	118
Diastolic Blood Pressure (1)	82
Blood Pressure taken in which Position (1)	2 - Sitting
Blood Pressure taken in which Arm (1)	Left
Pulse (1)	120
Characteristic of Pulse (1)	1 - Regular
Location Pulse was Taken (1)	2 - Radial
Respirations	28
O2 Via	1 - Nasal Cannula
Oxygen Use	3 - Continuous
Oxygen O2 Flow Rate (LPM)	6
Temperature	96.5
Temperature Degrees measured in	Fahrenheit
Location Temperature was Taken	3 - Axillary
Pain Status	Patient denies pain at this time.
Mental Status	1 - Alert - Oriented to
Mental Status Oriented to	Person
Mental Status Place	Place
Mental Status Time	Time
Neurological Status	NO SIGNIFICANT FINDINGS

Created: 6/8/2012 10:06:00AM

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Completed: 6/8/2012 10:58:00AM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Cardiovascular System	1 - Fatigue
Peripheral pulses - Pedal	9 - Tachycardia
Peripheral pulses - Notes	3 - Weak
Capillary refill	weak left pedal pulse
Edema	1 - Less than 3 seconds
Sensory/Communication	None noted
Venous Access	NO SIGNIFICANT FINDINGS
Conditions Affecting Respiratory Status	NA
	1 - Dyspnea with activity
	2 - Dyspnea at rest
	6 - Sleeps sitting up or requires more than 2 pillows
Breath Sound Condition	Rhonchi
Location of Lung Sounds	LLL
Breath Sound Condition	Diminished
Location of Lung Sounds	RML
	RLL
Productive Cough	1 - Yes
Color of Mucus	1 - Clear
Consistency of Mucus	1 - Thin
Amount of Mucus	1 - Small
Liver	NO SIGNIFICANT FINDINGS
Nutrition/Hydration	NO SIGNIFICANT FINDINGS
Ostomy	Ostomy Appliance (specify type)
Ostomy Type	colostomy
Ostomy Site	left abdomen
Bowel Sounds	active 4
Last Bowel Movement Date	06/07/2012
Stool softener of laxative required?	2 - No
GI/GU/Reproductive	NO SIGNIFICANT FINDINGS
Sexuality/Physical Contact/Closeness	2 - Deferred/Not Assessed
ADL - ROM	Limited
	Fall risk
ADL - Bathing	Assist
	Needs Met
ADL - Groom/Dress	Assist
	Needs Met
ADL - Eating/Oral Care	Independent
ADL - Ambulation	Assist
	Needs Met

Created: 6/8/2012 10:06:00AM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

ADL - Toileting

Assist

Fall Risk Not Assessed

Needs Met

Skin Integrity

Not Assessed

Issues related to imminent death

Patient does not have integrity issues at this time.

Care giving issues

No issues at present.

Emotional Status - Caregiver

No issues at present

Emotional Status - Patient

Mood/Affect stable and appropriate

Status of Plans for Funeral/Final Arrangements:

Mood/Affect stable and appropriate

Social Issues

1 - No plans initiated

Safety/Sanitation Issues:

NONE

Grief/Bereavement

None identified

Spiritual/Pastoral Concerns

Initiated Upon Admission

DME provider:

No Significant Finding

Assist devices/DME

Quality

Supervisory Visit

Has - Oxygen - Portable

Has - Oxygen - Concentrator

Not Assessed on this visit

Clinician DiagnosesResolvedDescription

Physical/symptom issues: pain, delirium, cognitive impairments, dyspnea, cough, wound, nausea, vomiting, anorexia, bladder incontinence, bowel incontinence, constipation, diarrhea, immobility, self-care deficit __

Psychosocial/emotional issues: agitation, anxiety, depression, stress, anticipatory grieving, denial, anger, ineffective coping, intimacy, self image, limited support system, substance abuse, mental illness __

Caregiver issues: anxiety, depression, anticipatory grieving, burden of care, limited support system, physical limitations, substance abuse, mental illness __

Functional/Safety issues: immobility, self-care deficit __

Spiritual issues: altered access to faith/spiritual community, alteration in spiritual practices, altered belief system, altered life's meaning, need for closure, spiritual distress __

Family/support issues: family conflict, communication, lack of resources, child/teen grief, role reversal, finances, inadequate housing __

OXYGEN Use/Safety

Palliative/Hospice Disease Management

PAIN MANAGEMENT

Symptom Management

Created: 6/8/2012 10:06:00AM

Printed: 8/26/2013 11:10:06AM

Completed: 6/8/2012 10:58:00AM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Fall/Safety Risk Prevention

Nutrition - End of Life

Grouped Clinician Diagnosis: Not Associated

InterventionsIntervention
Category:

NURSE CLINICAL SUMMARY

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Enter a summary of the NURSE Visit in the NOTE BOX. Include items that may require follow up. Background required on Admission clinical summary. Note: Routine visit	Y	N				N

Pts CG greeted SN at door. Upon arrival pt sitting in recliner watching tv. Pt reports that he had a breathing attack this morning and when his daughter called hospice she was put through to the answering service so daughter hung up. Daughter proceeded to call 911. Pt states EMS came to pts home and worked with him for about an hour helping him administer his medications and nebulizer treatments until pt returned to normal. SN explained that a nurse is on call for hospice 24 hours a day but each pt has to go through an answering service first. Family members asked if there was a nurse located near to pt that could help in situations like that that happened this morning and SN explained that 1 nurse was on call at night and no one else would be called based on location. SN explained that hospice covers 4 counties and the nurses live in several different areas but cannot be on call based on location. Family not really pleased with this information but reinforcement given that if pt called nurse on call she could talk him or another family member through what needs to be done before she got there. Family seemed a little more at ease with this information. Upon assessment vitals are stable except hr 120 and resp 28. Rhonchi is heard in left lower lobe of lung and right lung fields are diminished. Pt reports a productive cough producing clear phlegm at times. Pt wearing O2 at 3L but states that the type he is wearing it delivers twice as much O2 so he is receiving 6L. Pt reports severe SOB when pt has to get up and ambulate. Bowel sounds are present and brown stool noted in colostomy. Left pedal pulse is weak and no edema present. SN performed teaching about Roxanol and Ativan and discussed steps to do when having breathing difficulty. CG wrote instructions down. SN instructed pt to call hospice with any breathing difficulty or any other concerns. SN called pts pharmacy who confirms that pts Ativan and Roxanol are ready for pickup. SN informed pt to show pharmacy pts hospiscript card. Pt states that QHM will be delivering equipment today. No other needs noted at this time. SN encouraged pt and family to call hospice for any needs or concerns.

Continue hospice poc and monitor for decline. Please bring urinal to next scheduled visit.

Grouped Clinician Diagnosis: Nutrition - End of Life

InterventionsIntervention
Category:

DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Instruct on disease progression: s/sx of dying, potential for skin breakdown, urinary incontinence, decreased desire/ability to eat/drink and alternative treatment measures to increase comfort.	Y	N				N

Grouped Clinician Diagnosis: OXYGEN Use/Safety

Interventions

Created: 6/8/2012 10:06:00AM

Printed: 8/26/2013 11:10:06AM

Completed: 6/8/2012 10:58:00AM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Intervention Category: DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Evaluate need for/or effectiveness of oxygen therapy, instruct as needed.	Y	N				N

Grouped Clinician Diagnosis: Palliative/Hospice Disease Management

Interventions

Intervention Category: DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Instruct to call Hospice, not 911.	Y	N				N

Grouped Clinician Diagnosis: Physical/symptom issues: pain, delirium, cognitive impairments, dyspnea, cough, wound, nausea, vomiting, anorexia, bladder incontinence, bowel incontinence, constipation, diarrhea, immobility, self-care deficit __

Interventions

Intervention Category: DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Assess for medication effectiveness/symptom control; side effects and compliance.	Y	N				N
	Instruct on medication/supplement; purpose, action, and side effects.	Y	N				N
	Evaluate need/effectiveness/safety of equipment/supplies; initiate order as needed; instruct as needed	Y	N				N

Created: 6/8/2012 10:06:00AM

Printed: 8/26/2013 11:10:06AM

Completed: 6/8/2012 10:58:00AM

Author: Dunnaway, Alicia R RN

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

DOB: [REDACTED]

SOC: 06/07/2012

Spartanburg Regional Hospice

120 Heywood Ave

Suite 300

Spartanburg, SC 293021211

8645603900

Contains

SRHS IPU Spiritual Assessment

Hospice IDG Careplan 3 Non-Visit

Hospice IDG Careplan 3 Spiritual Visit Note

Date In: 6/11/2012 11:00:00AM

Date Out: 6/11/2012 11:15:00AM

Personnel: Jordan, Gary W Chaplain

SRHS IPU Spiritual AssessmentClinical Record Items

Patient Spiritual Perspective

3 - Protestant

Family Spiritual Perspective

3 - Protestant

Does patient or caregiver want Hospice to contact clergy?

2 - No

Spiritual Support

Fair - limited pastoral/congregational visitation

Support desired from spiritual community

1 - Clergy visits

5 - Prayer

Expresses faith in God

Patient - Yes

Major Spiritual Concerns

1 - Patient's spiritual doctrine/beliefs may affect end of life choices (spiritual conflict)

Clinician DiagnosesResolvedDescription

Physical/symptom issues: pain, delirium, cognitive impairments, dyspnea, cough, wound, nausea, vomiting, anorexia, bladder incontinence, bowel incontinence, constipation, diarrhea, immobility, self-care deficit __

Psychosocial/emotional issues: agitation, anxiety, depression, stress, anticipatory grieving, denial, anger, ineffective coping, intimacy, self image, limited support system, substance abuse, mental illness __

Caregiver issues: anxiety, depression, anticipatory grieving, burden of care, limited support system, physical limitations, substance abuse, mental illness __

Functional/Safety issues: immobility, self-care deficit __

Spiritual issues: altered access to faith/spiritual community, alteration in spiritual practices, altered belief system, altered life's meaning, need for closure, spiritual distress __

Family/support issues: family conflict, communication, lack of resources, child/teen grief, role reversal, finances, inadequate housing __

OXYGEN Use/Safety

Created: 6/11/2012 12:52:00PM

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Completed: 6/11/2012 1:28:00PM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Palliative/Hospice Disease Management

PAIN MANAGEMENT

Symptom Management

Fall/Safety Risk Prevention

Nutrition - End of Life

Grouped Clinician Diagnosis: Not Associated

Interventions

Intervention Category: CHAPLAIN CLINICAL SUMMARY

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Enter a summary of the CHAPLAIN Visit in the NOTE BOX. Include items that may require follow-up. Background required on Admission clinical summary. Note: SITUATION Patient is admitted into SRMC in the Heart Center. When chaplain arrived patient was receiving a breathing treatment. BACKGROUND Patient scheduled for spiritual assessment ASSESSMENT Patient was receiving breathing treatment as chaplain arrived. A visitor was sitting in room with patient. Visitor was not identified and patient stated that she did not talk. Patient asked chaplain to come back. RESPONSE Chaplain met patient to introduce spiritual support and chaplain services. Chaplain will visit with patient later in the week for further assessment.	Y	N				N

Grouped Clinician Diagnosis: Spiritual issues: altered access to faith/spiritual community, alteration in spiritual practices, altered belief system, altered life's meaning, need for closure, spiritual distress ____

Interventions

Intervention Category: PSYCHOSOCIAL - Spiritual/Chaplain

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Assess need for regular pastoral contacts as requested.	Y	N				N
	Provide spiritual support.	Y	N				N
	Provide support through: prayer, sacraments, scripture reading, meditation, religious services, presence, other ____.	Y	N				N

Created: 6/11/2012 12:52:00PM

Completed: 6/11/2012 1:28:00PM

Author: Jordan, Gary W Chaplain

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SN Visit No Charge (Visit 06/11/2012)

1629148936

pt in hospital

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

DOB: [REDACTED]

SOC: 06/07/2012

Spartanburg Regional Hospice

120 Heywood Ave

Suite 300

Spartanburg, SC 293021211

8645603900

Contains

Clinical Note

Date In: 6/11/2012 11:25:00AM

Date Out: 6/11/2012 11:44:00AM

Personnel: Ackerman, Adrian N RN

Telephone Visit

Clinical Note

Pt was admitted to Rm 8528 on 5Heart over the weekend. Nsg station #560-8262.

Sn called floor and spoke with Adam RN who is caring for pt today. Adam states pt was admitted with sob and as a full code. During the night pt required use of a bipap and family switched full code to a DNI. Pt had negative enzymes and is negative for PE. There were small elevations in troponin levels and blood culture results are pending. Adam states staff have continued education with family and patient regarding disease process and prognosis but also aggressive vs palliative care and pt is now a DNR. Palliative Care team has been consulted but had not seen patient yet. There are currently no discharge plans and the normal caseworker Yvonne is out but Alveta Brown is covering. Adam was also talking to pt while sn was on the phone with him - pt is oriented x3 and family was not with him. Adam stated they had no idea hospice was involved but sn explained that supervisors/medical director would be reviewing pt case and determine how to proceed and refine pts new poc. Sn called and discussed above findings with Sup S Carr and this sn will await a determination in poc before making visit with pt/family so that they will be aware of how care will proceed.

Created: 6/11/2012 5:20:00PM

Completed: 6/11/2012 5:51:00PM

Author: Ackerman, Adrian N RN

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Page 1 of 1

SN A Routine Visit (Visit 06/12/2012)



1629148956

visit to hospital rm 8528

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

DOB: [REDACTED]

SOC: 06/07/2012

Spartanburg Regional Hospice

120 Heywood Ave

Suite 300

Spartanburg, SC 293021211

8645603900

Contains

Hospice IDG Careplan 3 Non-Visit

Hospice IDG Careplan 3 Nursing Condition Progressing

Date In: 6/12/2012 8:51:00AM

Date Out: 6/12/2012 10:26:00AM

Personnel: Ackerman, Adrian N RN

Clinician DiagnosesResolvedDescription

Physical/symptom issues: pain, delirium, cognitive impairments, dyspnea, cough, wound, nausea, vomiting, anorexia, bladder incontinence, bowel incontinence, constipation, diarrhea, immobility, self-care deficit __

Psychosocial/emotional issues: agitation, anxiety, depression, stress, anticipatory grieving, denial, anger, ineffective coping, intimacy, self image, limited support system, substance abuse, mental illness __

Caregiver issues: anxiety, depression, anticipatory grieving, burden of care, limited support system, physical limitations, substance abuse, mental illness __

Functional/Safety issues: immobility, self-care deficit __

Spiritual issues: altered access to faith/spiritual community, alteration in spiritual practices, altered belief system, altered life's meaning, need for closure, spiritual distress __

Family/support issues: family conflict, communication, lack of resources, child/teen grief, role reversal, finances, inadequate housing __

OXYGEN Use/Safety

Palliative/Hospice Disease Management

PAIN MANAGEMENT

Symptom Management

Fall/Safety Risk Prevention

Nutrition - End of Life

Grouped Clinician Diagnosis: Fall/Safety Risk PreventionInterventionsIntervention
Category:

SAFETY

Identified: 06/07/2012

Achieved:

AchievedInterventionsPerformedVarVar TypeRsn CodeAct CodMove to
Next Visit
N

Instruct on need for caregiver to maintain safety in home environment.

Y

N

Created: 6/12/2012 8:32:00AM

Printed: 8/26/2013 11:10:06AM

Completed: 6/12/2012 10:16:00PM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Grouped Clinician Diagnosis: Not Associated

InterventionsIntervention
Category:

NURSE CLINICAL SUMMARY

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Enter a summary of the NURSE Visit in the NOTE BOX. Include items that may require follow up. Background required on Admission clinical summary. Note: Visit to hospital room 8528 5Heart.	Y	N				N

Pt oriented x3. 15L O2 nonrebreather rhonchi heard without stethoscope and pt is moderately sob at rest increasing with any activity. Wife Deloris at bedside but does not speak. Two of pts brothers present and were talking to Dr Littlefield when sn arrived. Pt told sn about what happened over the weekend and then repeated the story for msw Cheri when she arrived. Sn explained that there needed to be an adult in the home who could be educated on how to respond to a pt crisis as happened over the weekend. Pt strongly wants to go home but family at this time does not have the knowledge/ability to provide for pt care needs at this stage. Pt had been a full code upon admission changing then to a DNI and finally to a DNR. Sn encouraged hospice home transfer to assist with symptom management and help educate family on pt care needs. Sn discussed plans with Adam RN who cared for pt yesterday and Bruce RN who was caring for pt today. Sn also spoke with casemanager Yvonne and Dr Littlefield had already written an order for transfer to hospice home in pts chart this am. Sn called Dr Bell and discussed pt with him - he stated to just transfer pt based on Dr Littlefields orders and have Dr Snipes round on him at hospice home. Sn called Sup S Carr and then asked Yvonne to speak with Tracey Dawkins about transfer arrangements. When sn and Cheri re-entered pts room - son Billy who is also hcpoa was present so Cheri discussed updated poc with him and he strongly agreed that hospice home was the best option. Sn received call from Sup S Carr just after 2pm stating Billy had called and wanted more information and transport had already been set up for 230pm. Sn called and Billy was asking about symptom management - sn again explained that hospice treats symptoms aggressively as a palliative measure and that Dr Snipes would review pts current meds/treatments and continue with a poc he thought would be best for the pt to provide relieve and try to meet pt goals. Son then stated he needed to know what kind of routine would be set up at the home and when all hospice personel would be visiting because he felt he would have to pay a nurse to stay with pt intermittantly and he also wanted to know how to get equipment in pts home as pt was stating he was going to leave the hospice home on Saturday. Then pt was heard saying he expected to be home by Friday and son agreed. Sn explained again that the sequence of events would be that pt would be transferred and symptom management would be priority and tomorrow msw Toni at the hospice home would be visiting them to discuss pt care options. Son was in agreement with this plan. Sn then called Ashley RN at hospice home and informed her of all the above info - Toni was no longer there but Ashley agreed to make her aware of issues. Sn called msw Cheri to update her and she stated she would be calling Toni tomorrow to give her all the details.

Grouped Clinician Diagnosis: Nutrition - End of Life

InterventionsIntervention
Category:

DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
	Instruct on disease progression: s/sx of dying, potential for skin breakdown, urinary incontinence, decreased desire/ability to eat/drink and alternative treatment measures to increase comfort.	Y	N				N

Grouped Clinician Diagnosis: OXYGEN Use/Safety

Interventions

Created: 6/12/2012 8:32:00AM

Printed: 8/26/2013 11:10:06AM

Completed: 6/12/2012 10:16:00PM

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SN A Routine Visit (Visit 06/12/2012)



1629148956

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Intervention Category: DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	Evaluate need for/or effectiveness of oxygen therapy, instruct as needed.	Y	N				N

Grouped Clinician Diagnosis: Palliative/Hospice Disease Management

Interventions

Intervention Category: DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	Instruct to call Hospice, not 911.	Y	N				N

Intervention Category: INTERTEAM SERVICES/COMMUNITY REFERRALS

Identified: 06/07/2012 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	Instruct on/discuss any changes in patient condition or plan of care with caregiver/facility staff.	Y	N				N

Grouped Clinician Diagnosis: Psychosocial/emotional issues: agitation, anxiety, depression, stress, anticipatory grieving, denial, anger, ineffective coping, intimacy, self image, limited support system, substance abuse, mental illness

Interventions

Intervention Category: PSYCHOSOCIAL - Spiritual/Chaplain

Identified: 06/07/2012 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	Support communication/expression of feelings between patient and/or family members.	Y	N				N
	Evaluate meaning of death for patient/caregiver(s).	Y	N				N
	Support resolution of conflict.	Y	N				N
	Assess for feelings of hope/peace.	Y	N				N
	Evaluate sense of self	Y	N				N
	Provide information/education on end of life issues.	Y	N				N

Intervention Category: PSYCHOSOCIAL/SPIRITUAL/CULTURAL

Identified: 06/07/2012 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
	Evaluate patient/caregiver ability to cope with declining physical status.	Y	N				N
	Evaluate ability to cope with the grieving process.	Y	N				N

Created: 6/12/2012 8:32:00AM

Printed: 8/26/2013 11:10:06AM

Completed: 6/12/2012 10:16:00PM

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SN A Routine Visit (Visit 06/12/2012)



1629148956

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Created: 6/12/2012 8:32:00AM
Completed: 6/12/2012 10:16:00PM

Printed: 8/26/2013 11:10:06AM

Author: Ackerman, Adrian N RN

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Page 4 of 4

MSW Rt Visit (Visit 06/12/2012)



1652148447

visit at SRMC

Customer: Farr, William G
Customer ID: 03570052
Admit ID: 00038224
DOB: [REDACTED]
SOC: 06/07/2012

Spartanburg Regional Hospice

120 Heywood Ave

Suite 300

Spartanburg, SC 293021211

8645603900

Contains

Clinical Note

Date In: 6/12/2012 9:03:00AM

Date Out: 6/12/2012 10:20:00AM

Personnel: Freeman, Cheri LBSW

PRN Visit

Clinical Note

visit at SRMC. Pt was admitted to Hospice on 6/7 and to SRMC over the weekend. Pt had called EMS secondary to shortness of breath. Pt admitted to SRMC prior to SW admission visit in the home and LBSW was meeting pt for the first time. SN, Adrian, present. Pt was alert and oriented. Spouse and 2 of pts brotheres were in the room. Pts spouse did not talk and family advised that spouse has not talked in years secondary to an emotional/psychological problem. Pt talked about calling 911 and frustration about waiting for an SN to visit at the house that day. Pt stated that his chest was very tight. Pt currently on 15 liter non-rebreather mask and pt became very short of breath while talking. Discussed options for pts care with pt stating that he wants to go home. Discussed concerns re: pts current symptoms and no one in the home 24/7 that can meet current needs. Discussed need to get symptoms managed prior to pt trying to go back home or he will end up right back in the hospital. Pt stated that he has a sister who is very experienced with caring for people and he thinks she will assist with care. Pt verbalized agreement with transfer to the Hospice House during this visit for assistance with symptom management. LBSW asked pt who he wants to make decisions if/when he can't and he stated that his son, Brian, will take care of things for him. LBSW conferenced with case manager, Yvonne, and son arrived prior to LBSW leaving. Brian agreeable with transfer to the Hospice House. Pt had fallen asleep and Brian stated that he would talk to pt when he woke up. Emotional support provided. Anticipate transfer to Hospice House today.

Created: 6/12/2012 7:04:00PM

Completed: 6/12/2012 7:28:00PM

Author: Freeman, Cheri LBSW

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Printed: 8/26/2013 11:10:06AM

Case Communication Report

By Organization, By Entry User

Customer: Farr, William G - 03570052
Admit ID: 00038224
SRHS/SRMC/SRHC/SRHO
CHALMI - Chalk, Miranda

Customer: Farr, William G - 03570052
Organization: SRHS/SRMC/SRHC/SRHO
Type: ME--Medications
Author: Chalk, Miranda D
Subject: Medications
Note: dr.mehta to fax rx for roxanol and ativan to Cvs on rice ave. meds added to hospiscript profile confirm # 3401566

Admit ID: 00038224
Entered: 6/7/2012 5:29:33PM **by:** Chalk, Miranda
Completed: **by:**

COMEDI - Comer, Dina

Customer: Farr, William G - 03570052
Organization: SRHS/SRMC/SRHC/SRHO
Type: av--Attempted Visit
Author: Comer, Dina C RN
Subject: Attempted Visit
Note:

Admit ID: 00038224
Entered: 6/10/2012 4:26:42PM **by:** Comer, Dina
Completed: 6/10/2012 4:26:41PM **by:** Comer, Dina

sn recieved call this morning stating pt had been vomiting all night and his legs were swollen and aksed that sn visit today. sn informed i would. sn placed call back about 1 hour later stating a crisis had come up and sn called to check on pt to see how he was and would be a little later coming out. sn spoke with daughter who states pt was ok and wasnt vomiting but legs werre swollen. sn informs swelling probabllly related to cancer and sn would visit as soon as possible. daughter voiced satisfaction. sn made visit to home at 1245pm and was greeted at door by adult male who states pt had gone to hospital. sn questioned why and he states pt had sob. sn placed call to lisa pt daughter to inquire what happened to pt. sn informed she told sn earlier that pt legs were swollen and had vomited last night but didnt say anything about sob. lisa states pt just kept complaining of this and that and she called ems to transprt to srmc. sn offered emotional support and states will let primary nurse know .

SPROWA - Sprouse, Wanda

Customer: Farr, William G - 03570052
Organization: SRHS/SRMC/SRHC/SRHO
Type: EN--Episode Note - General
Author: Sprouse, Wanda Lanie
Subject: Episode Note - General
Note:

Admit ID: 00038224
Entered: 6/13/2012 1:21:03PM **by:** Sprouse, Wanda
Completed: 6/13/2012 1:21:01PM **by:** Sprouse, Wanda

Admitted to 5 Heart by Dr Littlefield On 6/10/12 transferred to Hospice Home on 6/12/12

STATVI - State, Vickie

Customer: Farr, William G - 03570052
Organization: SRHS/SRMC/SRHC/SRHO
Type: EN--Episode Note - General
Author: State, Vicki
Subject: Hospice Home stay from 06.12.12 to 06.16.12 Documentation is in episode 38311
Note:

Admit ID: 00038224
Entered: 6/18/2012 4:14:17PM **by:** State, Vickie
Completed: 6/18/2012 4:14:16PM **by:** State, Vickie

Please see episode 38311 for IPU documentation.

TAYLCL - Taylor, Clegg

Customer: Farr, William G - 03570052
Organization: SRHS/SRMC/SRHC/SRHO
Type: EN--Episode Note - General
Author: Taylor, Clegg F Chap
Subject: POC
Note:

Admit ID: 00038224
Entered: 6/7/2012 10:50:02PM **by:** Taylor, Clegg
Completed: 6/7/2012 10:50:01PM **by:** Taylor, Clegg

The chaplain reviewed the POC written by the admitting RN

Report Range Definition

Groups: By Organization, By Entry User
Show note text: Yes
Show follow up info: No
Category: CASE CONFERENCE NOTE
Include incomplete notes: Yes
Include incomplete follow-up notes: Yes
Include discharged patients: Yes
Include entry date range: Yes From: 06/07/2012 thru: 08/26/2013
Include follow-up due date range: No
Include follow-up complete date range: No
Include complete date range: No

Note Types: All Note Types were selected

Entry Users: All Entry Users were selected

Authors: All Authors were selected

Follow-up Persons: All Follow-up Persons were selected

Completion Users: All Completion Users were selected

Admissions: Farr, William G - Admit ID: 00038224

Organizations: All Organizations were selected

Database: PwhcProd01

User: JOHNTA - Johnson, Tara

Exe version: C:\MCKESSON\PWHC\APPS.exe - 12.3.2

Command line: /si:\\PRC162K8\McKesson\Pwhc\Config\Prod01\ /AN: Print Notes Report /EX:HXYMGL /UC:178358 /UP:112

**Documentation Summary
Spartanburg Regional Hospice Home**

Sort By Patient All Disciplines Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient Farr, William G	IPU SOC 06/10/2012	Room	Admit ID 00038311	Patient ID 03570052	LOC
Performed On 06/12/2012 03:50 PM	Document Type Assessment		Performed By Ashleigh Pinto RN	Entered On 06/12/2012 04:11 PM	
Completed On	06/12/2012 04:41 PM				

Intervention: IPU SN Admission Assessment

Notes:

Assessment: SRHS IPU Nursing Assessment - Admission

Observation

Reason for Admission
Currently a Regional Hospice Patient
Patient demonstrates knowledge/understanding of disease process

Patients illness is related to:
Patient denies pain at this time
Pain Observations
Mental Status
Oriented to

Sleep/Rest
Neurological Status
Sensory/Communication
Patients ability to express self
Weight kg
Weight
Height inches
Appetite
Diet
Oral Cavity
GI Abdomen

Ostomy Appliance
Bowel Sounds
Last bowel movement
GU
Edema
Breath Sounds
Pulmonary

Oximizer L/min
Liver
Bathing
Integument

Result

Sx management
Current Regional Hospice patient
Treatment Plan

Disease Progression
Prognosis
DNR
Cancer
Patient denies pain at this time
No non-verbal signs of pain
Alert
Person
Place
Time
No Significant Changes for Patient
No Significant Findings
No significant findings
Express thoughts, feelings, needs w/o difficulty
54
Stated
64
Good
As tolerated
No significant findings
Flat
Soft
Colostomy
Active
06/12/2012
No Significant Findings
None noted
Clear
Regular
Dyspnea
Dyspnea on exertion
O2 Therapy
15
No Significant Findings
Partial assist
Warm

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	Turgor				Loose
	Vascular Access Type				Implanted Device (Port, etc)
					Port accessed
	Port accessed				Date flushed
	Port accessed date flushed				06/12/2012
	Vascular access site location				1 sc pac
	Vascular Access Site				Benign
	Patency				Flushes easily
					Blood return
	Vascular access dressing type				Transparent
	Vascular access dressing condition				Clean, dry, intact
	Subcutaneous Access				NA
	Issues Related to Imminent Death				No issues at present
	Emotional Status				Mood/Affect stable and appropriate
	Potential Learning Factors - Emotional Status (anxiety/fear etc)				Patient
	Potential Learning Factors - Other (specify)				daughter does not want pt here, or on the hospice program
	Patient Bill of Rights/Responsibilities				Discussed
	Discussed with				Patient
					Other
	Discussed with other				brian farr
	Other Relationship				son

Performed On	Document Type	Performed By	Entered On
06/12/2012 03:50 PM		Ashleigh Pintoff RN	06/12/2012 04:11 PM
Completed On	Intervention		
	06/12/2012 04:41 PM		

Intervention: IPU SN Admission Assessment
Notes:

Performed On	Document Type	Performed By	Entered On
06/12/2012 04:20 PM		Ashleigh Pintoff RN	06/12/2012 04:20 PM
Completed On	Intervention		
	06/12/2012 04:41 PM		

Intervention: IPU SN Fall Risk Assessment
Notes:

Performed On	Document Type	Performed By	Entered On
06/12/2012 04:20 PM		Ashleigh Pintoff RN	06/12/2012 04:20 PM
Completed On	Assessment		
	06/12/2012 04:41 PM		

Intervention: IPU SN Fall Risk Assessment
Notes:

Assessment: SRHS IPU Fall Risk Assessment

Observation
 Fall Score

Result
 0

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines

Sort By Patient

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	Mobility Score			2	
	Uncooperative or unable to follow directions score			0	
	Total Score			2	

Performed On	Document Type	Performed By	Entered On
06/12/2012 04:21 PM		Ashleigh Pintooff RN	06/12/2012 04:30 PM
Completed On	Intervention		
	06/12/2012 04:41 PM		

Intervention: IPU SN Shift Summary

Notes: admitted from srmc 5heart this shift, for symptom management with decision to d/c home on Friday with Home Hospice. son and wife are at bedside during admission and state acceptance that pt is here to stabilize and go home Friday. Daughter arrives very upset and not on the Hospice page at all, and states to the RN that he, her father, is not here for us to pump Morphine into and kill off. RN stated that she was sorry that somewhere she was mis-informed, but that is not what we do here. She replied "well whatever, I have a two year old and cannot be here around the clock and we need to be on the same page." Notified Dr. Snipes and Tracey Dawkins regarding family conflict and family meeting took place. Non-Rebreather replaced with and oximizer per pt request, he states he is hot, sweaty, and can't eat with the mask on, pt tolerating the oximizer well. emotional support provided to pt and frequent rounding noted.

Performed On	Document Type	Performed By	Entered On
06/12/2012 04:21 PM		Ashleigh Pintooff RN	06/12/2012 04:21 PM
Completed On	Intervention		
	06/12/2012 04:41 PM		

Intervention: IPU Instruct on pain management and use of 0-10 pain scaleNotes:

Performed On	Document Type	Performed By	Entered On
06/12/2012 04:21 PM		Ashleigh Pintooff RN	06/12/2012 04:21 PM
Completed On	Intervention		
	06/12/2012 04:41 PM		

Intervention: IPU Instruct Hospice orientation booklet and obtain necessary signatures on appropriate consent formsNotes:

Performed On	Document Type	Performed By	Entered On
06/12/2012 04:21 PM		Ashleigh Pintooff RN	06/12/2012 04:21 PM
Completed On	Intervention		
	06/12/2012 04:41 PM		

Intervention: IPU Instruct on other symptom managementNotes:

Performed On	Document Type	Performed By	Entered On
06/12/2012 04:45 PM		Iris Caldwell PCT	06/12/2012 07:17 PM
Completed On	Intervention		
	06/12/2012 07:28 PM		

Intervention: IPU Hospice Aide Patient EncounterNotes:

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Performed On	Document Type	Performed By	Entered On
06/12/2012 04:45 PM		Iris Caldwell PCT	
Completed On	Intervention		06/12/2012 07:18 PM
	06/12/2012 07:28 PM		

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)

Notes: temp97.4 ax

pulse101

resp29

bp 114/82 L

Performed On	Document Type	Performed By	Entered On
06/12/2012 07:55 PM		Norma White PCT	
Completed On	Intervention		06/12/2012 10:43 PM
	06/13/2012 04:12 AM		

Intervention: IPU Hospice Aide Patient Encounter

Notes:

Performed On	Document Type	Performed By	Entered On
06/12/2012 10:43 PM		Norma White PCT	
Completed On	Intervention		06/12/2012 10:43 PM
	06/13/2012 04:12 AM		

Intervention: IPU Fall precautions:

Notes: bed in low position; call light at bedside; family in room

Performed On	Document Type	Performed By	Entered On
06/13/2012 04:08 AM		Norma White PCT	
Completed On	Intervention		06/13/2012 04:08 AM
	06/13/2012 04:13 AM		

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)

Notes: 0 output during shift

Performed On	Document Type	Performed By	Entered On
06/13/2012 04:24 AM		Melissa Peterson RN	
Completed On	Assessment		06/13/2012 04:24 AM
	06/13/2012 07:53 AM		

Intervention: IPU SN Fall Risk Assessment

Notes:

Assessment: SRHS IPU Fall Risk Assessment

Observation

Medication:

Medication Score

Patient has medical condition which could impair their ability to ambulate

Result

Narcotic = 1

1

Chronic debilitating illness = 1

Documentation Summary
Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	Patient has medical condition which could impair their ability to ambulate Score				1
	Total Score				2

Performed On	Document Type	Performed By	Entered On
06/13/2012 04:24 AM			
Completed On	Assessment	Melissa Peterson RN	06/13/2012 04:24 AM
	06/13/2012 07:53 AM		

Intervention: IPU SN Fall Risk Assessment

Notes:

Assessment: SRHS IPU Fall Risk Assessment

Observation	Result
Medication:	Narcotic = 1
Medication Score	1
Patient has medical condition which could impair their ability to ambulate	Chronic debilitating illness = 1
Patient has medical condition which could impair their ability to ambulate Score	1
Total Score	2

Performed On	Document Type	Performed By	Entered On
06/13/2012 04:24 AM			
Completed On	Intervention	Melissa Peterson RN	06/13/2012 04:24 AM
	06/13/2012 07:53 AM		

Intervention: IPU SN Fall Risk Assessment

Notes:

Performed On	Document Type	Performed By	Entered On
06/13/2012 04:24 AM			
Completed On	Intervention	Melissa Peterson RN	06/13/2012 04:24 AM
	06/13/2012 07:53 AM		

Intervention: IPU SN Fall Risk Assessment

Notes:

Performed On	Document Type	Performed By	Entered On
06/13/2012 06:16 AM			
Completed On	Intervention	Melissa Peterson RN	06/13/2012 07:50 AM
	06/13/2012 07:53 AM		

Intervention: IPU IV Med Admin/PCA bag change or dose change

Notes:

Performed On	Document Type	Performed By	Entered On
06/13/2012 06:16 AM			
Completed On	Intervention	Melissa Peterson RN	06/13/2012 07:51 AM
	06/13/2012 07:53 AM		

Documentation Summary**Spartanburg Regional Hospice Home****Sort By Patient****All Disciplines****Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> pt was given morphine 2mg because he was having trouble breathing, labored,					
Performed On 06/13/2012 06:16 AM	Document Type	Performed By		Entered On	
Completed On	Intervention	Melissa Peterson RN		06/13/2012 07:50 AM	
	06/13/2012 07:53 AM				
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change					
<u>Notes:</u>					
Performed On 06/13/2012 06:16 AM	Document Type	Performed By		Entered On	
Completed On	Intervention	Melissa Peterson RN		06/13/2012 07:51 AM	
	06/13/2012 07:53 AM				
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> pt was given morphine 2mg because he was having trouble breathing, labored,					
Performed On 06/13/2012 06:46 AM	Document Type	Performed By		Entered On	
Completed On	Intervention	Melissa Peterson RN		06/13/2012 07:51 AM	
	06/13/2012 07:53 AM				
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> pt states that he feels much better.					
Performed On 06/13/2012 06:46 AM	Document Type	Performed By		Entered On	
Completed On	Intervention	Melissa Peterson RN		06/13/2012 07:51 AM	
	06/13/2012 07:53 AM				
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> pt states that he feels much better.					
Performed On 06/13/2012 06:46 AM	Document Type	Performed By		Entered On	
Completed On	Intervention	Melissa Peterson RN		06/13/2012 07:51 AM	
	06/13/2012 07:53 AM				
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> pt states that he feels much better.					
Performed On 06/13/2012 08:06 AM	Document Type	Performed By		Entered On	
Completed On	Intervention	Gloria Davis RN		06/13/2012 08:48 AM	
	06/13/2012 01:30 PM				
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change					
<u>Notes:</u>					
Performed On 06/13/2012 08:06 AM	Document Type	Performed By		Entered On	
Completed On	Intervention	Gloria Davis RN		06/13/2012 08:45 AM	
	06/13/2012 01:30 PM				

Documentation Summary
Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Intervention: IPU SN Perform Daily Assessment

Notes:

Performed On	Document Type	Performed By	Entered On
06/13/2012 08:06 AM		Gloria Davis RN	06/13/2012 08:45 AM
Completed On	Assessment		
	06/13/2012 01:30 PM		

Intervention: IPU SN Perform Daily Assessment

Notes:

Assessment: SRHS IPU Nursing Assessment Routine 2

Observation

Patient denies pain at this time
Pain Observations
Mental Status
Oriented to

Neurological Status
Patients ability to express self
Appetite
Diet
Oral Cavity
GI Abdomen
Bowel Sounds
Last bowel movement
GU
Cardiovascular System

Peripheral Pulses
Edema
Breath Sounds
Pulmonary

Oximizer L/min
Pulmonary
Liver
Bathing
Eating/Oral Care
Ambulation
Integument

Turgor
Vascular Access Type

Vascular access site location
Vascular Access Site
Patency
Vascular access dressing type

Result

Patient denies pain at this time
No non-verbal signs of pain
Alert
Person
Place
Time
No Significant Findings
Express thoughts, feelings, needs w/o difficulty
Poor
As tolerated
No significant findings
Soft
Active
06/13/2012
No Significant Findings
Tachycardia
Temperature change to lower extremities
No Significant Findings
None noted
Rhonci
Regular
Dyspnea
Dyspnea on exertion
O2 Therapy
15
Nebulizer treatment
No Significant Findings
Partial assist
Independent
Partial assist
Warm
Dry
Loose
Implanted Device (Port, etc)
Port accessed
LSCL
Benign
Flushes easily
Transparent

Documentation Summary**Spartanburg Regional Hospice Home****Sort By Patient****All Disciplines****Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Patient Farr, William G	IPU SOC 06/10/2012	Room	Admit ID 00038311	Patient ID 03570052	LOC Clean, dry, intact NA No issues at present Mood/Affect stable and appropriate
Performed On 06/13/2012 08:06 AM	Document Type Intervention		Performed By Gloria Davis RN		Entered On 06/13/2012 08:48 AM
Completed On	06/13/2012 01:30 PM				

Intervention: IPU IV Med Admin/PCA bag change or dose changeNotes:

Performed On 06/13/2012 11:45 AM	Document Type Intervention		Performed By Gloria Davis RN		Entered On 06/13/2012 11:48 AM
Completed On	06/13/2012 01:30 PM				

Intervention: IPU IV Med Admin/PCA bag change or dose changeNotes:

Performed On 06/13/2012 11:45 AM	Document Type Intervention		Performed By Gloria Davis RN		Entered On 06/13/2012 11:49 AM
Completed On	06/13/2012 01:30 PM				

Intervention: IPU PRN Medication/FollowUpNotes: medicated with morphine 2 mg in for dyspnea and shakiness

Performed On 06/13/2012 11:45 AM	Document Type Intervention		Performed By Gloria Davis RN		Entered On 06/13/2012 11:48 AM
Completed On	06/13/2012 01:30 PM				

Intervention: IPU IV Med Admin/PCA bag change or dose changeNotes:

Performed On 06/13/2012 11:45 AM	Document Type Intervention		Performed By Gloria Davis RN		Entered On 06/13/2012 11:49 AM
Completed On	06/13/2012 01:30 PM				

Intervention: IPU PRN Medication/FollowUpNotes: medicated with morphine 2 mg in for dyspnea and shakiness

Performed On 06/13/2012 12:15 PM	Document Type Intervention		Performed By Jamica Mayes PCT		Entered On 06/13/2012 06:41 PM
Completed On	06/13/2012 06:42 PM				

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines

Sort By Patient

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Intervention: IPU Bath: _____

Notes:

Performed On 06/13/2012 12:15 PM	Document Type Intervention	Performed By Jamica Mayes PCT	Entered On 06/13/2012 06:41 PM
Completed On 06/13/2012 06:42 PM			

Intervention: IPU Hospice Aide Patient Encounter

Notes:

Performed On 06/13/2012 12:17 PM	Document Type Intervention	Performed By Gloria Davis RN	Entered On 06/13/2012 12:21 PM
Completed On 06/13/2012 01:30 PM			

Intervention: IPU SN Shift Summary

Notes: 69 y/o male

Lung ca/Cpod

GIP

Alert and oriented x 3/able to make his own decisions re care and meds at this time

O2 at 10l/min via oxymizer/O2 decreased to 10L at pts request

Medicated x 3 with morphine 2 mg iv and x 1 with ativan 1mg for sob/shakiness and acute exacerbation of dyspnea with good results

Appears comfortable

Family at the bedside

Emotional support provided

Performed On 06/13/2012 12:17 PM	Document Type Intervention	Performed By Gloria Davis RN	Entered On 06/13/2012 12:17 PM
Completed On 06/13/2012 01:30 PM			

Intervention: IPU PRN Medication/FollowUp

Notes: pat states "I'm feeling pretty good now"/medication effective

Performed On 06/13/2012 12:17 PM	Document Type Intervention	Performed By Gloria Davis RN	Entered On 06/13/2012 12:17 PM
Completed On 06/13/2012 01:30 PM			

Intervention: IPU PRN Medication/FollowUp

Notes: pat states "I'm feeling pretty good now"/medication effective

Performed On 06/13/2012 12:17 PM	Document Type Intervention	Performed By Gloria Davis RN	Entered On 06/13/2012 12:21 PM
Completed On 06/13/2012 01:30 PM			

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Intervention: IPU SN Shift Summary
Notes: 69 y/o male
 Lung ca/Cpod
 GIP
 Alert and oriented x 3/able to make his own decisions re care and meds at this time
 O2 at 10l/min via oxymizer/O2 decreased to 10L at pts request
 Medicated x 3 with morphine 2 mg iv and x 1 with ativan 1mg for sob/shakiness and acute exacerbation of dyspnea with good results
 Appears comfortable
 Family at the bedside
 Emotional support provided

Performed On	Document Type	Performed By	Entered On
06/13/2012 12:21 PM		Gloria Davis RN	06/13/2012 12:22 PM

Completed On Intervention
 06/13/2012 01:30 PM

Intervention: IPU Conference with Social Worker
Notes: IDG

Performed On	Document Type	Performed By	Entered On
06/13/2012 12:21 PM		Gloria Davis RN	06/13/2012 12:22 PM

Completed On Intervention
 06/13/2012 01:30 PM

Intervention: IPU Conference with Social Worker
Notes: IDG

Performed On	Document Type	Performed By	Entered On
06/13/2012 12:22 PM		Gloria Davis RN	06/13/2012 12:22 PM

Completed On Intervention
 06/13/2012 01:30 PM

Intervention: IPU Conference with Hospice Aide
Notes:

Performed On	Document Type	Performed By	Entered On
06/13/2012 12:22 PM		Gloria Davis RN	06/13/2012 12:22 PM

Completed On Intervention
 06/13/2012 01:30 PM

Intervention: IPU Conference with Physician
Notes: IDG

Performed On	Document Type	Performed By	Entered On
06/13/2012 12:22 PM		Gloria Davis RN	06/13/2012 12:22 PM

Completed On Intervention
 06/13/2012 01:30 PM

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
<u>Intervention:</u> IPU Conference with Hospice Aide					
<u>Notes:</u>					
Performed On 06/13/2012 12:22 PM	Document Type		Performed By Gloria Davis RN	Entered On 06/13/2012 12:22 PM	
Completed On	Intervention 06/13/2012 01:30 PM				
<u>Intervention:</u> IPU Conference with Physician					
<u>Notes:</u> IDG					
Performed On 06/13/2012 12:35 PM	Document Type		Performed By Gloria Davis RN	Entered On 06/13/2012 01:11 PM	
Completed On	Intervention 06/13/2012 01:30 PM				
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> morphine 4 mg and ativan 1mg iv given for acute resp distress					
Performed On 06/13/2012 12:35 PM	Document Type		Performed By Gloria Davis RN	Entered On 06/13/2012 01:10 PM	
Completed On	Intervention 06/13/2012 01:30 PM				
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change					
<u>Notes:</u>					
Performed On 06/13/2012 12:35 PM	Document Type		Performed By Gloria Davis RN	Entered On 06/13/2012 01:10 PM	
Completed On	Intervention 06/13/2012 01:30 PM				
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change					
<u>Notes:</u>					
Performed On 06/13/2012 12:35 PM	Document Type		Performed By Gloria Davis RN	Entered On 06/13/2012 01:11 PM	
Completed On	Intervention 06/13/2012 01:30 PM				
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> morphine 4 mg and ativan 1mg iv given for acute resp distress					
Performed On 06/13/2012 01:00 PM	Document Type		Performed By Gloria Davis RN	Entered On 06/13/2012 01:11 PM	
Completed On	Intervention 06/13/2012 01:30 PM				

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Intervention: IPU PRN Medication/FollowUp
Notes: medication effective/pt much better now

Performed On	Document Type	Performed By	Entered On
06/13/2012 01:00 PM		Gloria Davis RN	06/13/2012 01:11 PM
Completed On	Intervention		
06/13/2012 01:30 PM			

Intervention: IPU PRN Medication/FollowUp
Notes: medication effective/pt much better now

Performed On	Document Type	Performed By	Entered On
06/13/2012 03:18 PM		Antoinette Sanders MSW	06/13/2012 06:08 PM
Completed On	Intervention		
06/13/2012 07:33 PM			

Intervention: IPU SW Patient Encounter Admission
Notes:

Performed On	Document Type	Performed By	Entered On
06/13/2012 06:08 PM		Antoinette Sanders MSW	06/13/2012 06:09 PM
Completed On	Assessment		
06/13/2012 07:33 PM			

Intervention: IPU SW Perform Initial Assessment
Notes:

Assessment: SRHS IPU Psychosocial Intial Assessment

Observation
 Current Regional Hospice Patient
 Individual's Participating in Interview

 Individual's Participating in Interview Notes

 Name of Partner or Spouse
 Duration of Relationship
 Anniversary Date
 Does Partner/Spouse function as Primary Caregiver?
 Name of Member of Household (1)
 Age (1)
 Member of household
 Relationship to Patient (1)
 Member Actively Involved in Care (1)
 Members of Household Notes

Social Support Systems

Result
 Current Regional Hospice Patient
 Lisa
 dtr
 Deloris
 spouse
 pt
 Sisters Ann and Faye arrived at conclusion of visit
 Deloris
 50 years
 11/08/2012
 1 - Yes

 Deloris
 60s
 1 - Yes
 spouse
 1 - Yes
 son Brian involved in care and dtr Lisa lives in columbia and voices her availability to assist once pt is discharged home
 0 - Excellent social support system which includes three or more willing family members or

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	Social Support System Notes			friends	
	Abuse/Neglect			close family living in close proximity of one another. pt has 3 sisters and 3 brothers	
	Mental Status			No signs of abuse/neglect	
				1 - Alert - Oriented to:	
				Person	
				Place	
				Time	
	Does the Patient or Family have any concerns about the patients mental status?			2 - No	
	Emotional Status - Patient			Mood/Affect stable and appropriate	
	Emotional Status Notes			Spouse does not speak. pt dtr adamant that pt will walk out of the hospice home	
	Patient Coping Mechanisms			Patient demonstrates a healthy mix of coping strategies to achieve end of life goals	
	Sources of Stress/Grief in Addition to Patients Current Illness or Death:			1 - Accepting	
	Patient Current Employment Status			None reported	
	Patient retired - Life occupation			6 - Retired	
	Source of Income			self employed	
	Financial concerns expressed by patient or spouse/SO			social security	
	Patient needs the following services:			No concerns expressed	
	Patient needs the following services - Other			5 - Other	
	Status of Plans for Funeral/Final Arrangements:			referral to hospice agency in Union	
	Name of Funeral Home			2 - Plans in Process	
	Status of Plans for Funeral/Final Arrangements:			Holcombes	
				2 - Plans in Process	

Performed On
06/13/2012 06:08 PM
Completed On

Document Type

Intervention

06/13/2012 07:33 PM

Performed By
Antoinette Sanders MSW

Entered On

06/13/2012 06:09 PM

Intervention: IPU SW Perform Initial AssessmentNotes:

Performed On
06/13/2012 06:16 PM
Completed On

Document Type

Intervention

06/13/2012 07:33 PM

Performed By
Antoinette Sanders MSW

Entered On

06/13/2012 06:17 PM

Intervention: IPU End of Life decisions/planningNotes: Holcombes

Performed On
06/13/2012 06:16 PM
Completed On

Document Type

Intervention

06/13/2012 07:33 PM

Performed By
Antoinette Sanders MSW

Entered On

06/13/2012 06:16 PM

Intervention: IPU Provide Psychosocial counseling

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Notes:

Performed On	Document Type	Performed By	Entered On
06/13/2012 06:17 PM		Antoinette Sanders MSW	06/13/2012 06:17 PM
Completed On	Intervention		
06/13/2012 07:33 PM			

Intervention: IPU Discharge planningNotes: pt desires to be discharged home by the end of the week if possible

Performed On	Document Type	Performed By	Entered On
06/13/2012 06:17 PM		Antoinette Sanders MSW	06/13/2012 06:18 PM
Completed On	Intervention		
06/13/2012 07:33 PM			

Intervention: IPU Conference with PhysicianNotes: in idg

Performed On	Document Type	Performed By	Entered On
06/13/2012 06:17 PM		Antoinette Sanders MSW	06/13/2012 06:17 PM
Completed On	Intervention		
06/13/2012 07:33 PM			

Intervention: IPU Conference with NurseNotes: in idg

Performed On	Document Type	Performed By	Entered On
06/13/2012 06:18 PM		Antoinette Sanders MSW	06/13/2012 06:31 PM
Completed On	Intervention		
06/13/2012 07:33 PM			

Intervention: IPU SW Shift SummaryNotes: pt is a 69 year old male diagnosed with lung Ca/COPD.

msw conferenced with LBSW Cheri who visited pt at the hospital but was unable to complete an assessment.

msw and prn SW Patti completed initial assesment with pt and his dtr Lisa. Lisa is of the belief that the hospice home is an evil place where we administer morphine until our pts die. she states this is the belief in the community as well. msw provided education to her regarding her misconceptions and beliefs about hospice services and hospice home services. msw explained that many pts are discharged alive and that was the plan for her father. She became teary eyed a couple of times when msw addressed her misconceptions and love for her father. However, her faith will not allow her to believe that her father will die. she believes that weak, unfaithful, and unbelieving people die to cancer and those who speak negatively fulfill their own prophecies. She explains she has researched morphine and hospice and she stands by her belifes. Regardless of how many times msw redirected her focus and attention to discharge plans she reverted back to her beliefs about hospice and morphine and the fact that her father was going to walk out of the hospice home. During my conversation with Lisa, pt was asleep but when he awakened, msw engaged him in conversattion. Pt states he is wel aware of his situation and although his goal is to see his granddtr Victoria graduate, he realizes this dream may not materialize. msw voiced concerns about Lisa and he stated that people have to realize that no one lives forever. This msw found him to be realistic about his diagnosis while supporting his decision to return home. He is in agreement with the plan to use a hospice agency in Union and msw will help coordinate plans.

Documentation Summary
Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Pt states he owned his own Red Dot/convenience/cafe store until he sold it. he receives social security. He and his wife, who does not speak, have been married for 50 years and they have two children. Their son Brian lives in B.Springs. Pt has 3 brothers and 3 sisters and two visited towards the conclusion of the visit. They live within close proximity of one another and Lisa describes them as a close knit family. Pt also enjoys gardening and watching football. Funeral plans are with Holcombe's.

msw provided education, emotional support, and active listening.

Performed On	Document Type	Performed By	Entered On
06/13/2012 06:41 PM		Jamica Mayes PCT	
Completed On	Intervention		06/13/2012 06:42 PM
	06/13/2012 06:42 PM		

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)

Notes: T-97.7

P-128

R-38

BP-128/64

BKF-100

LUNCH-100

DINNER-TRAY STILL AT PATIENT BEDSIDE

OUTPUT-
BM-

Performed On	Document Type	Performed By	Entered On
06/13/2012 09:40 PM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:39 AM
	06/14/2012 07:30 AM		

Intervention: IPU PRN Medication/FollowUp

Notes: dyspneic/anxious; Morphine 4mg IV

Performed On	Document Type	Performed By	Entered On
06/13/2012 09:40 PM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:39 AM
	06/14/2012 07:30 AM		

Intervention: IPU PRN Medication/FollowUp

Notes: dyspneic/anxious; Morphine 4mg IV

Performed On	Document Type	Performed By	Entered On
06/13/2012 09:55 PM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:40 AM
	06/14/2012 07:30 AM		

Intervention: IPU PRN Medication/FollowUp

Notes: cont to be restless and difficulty slowing RR down (68); Lorazepam 1mg IV

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Performed On	Document Type	Performed By	Entered On
06/13/2012 09:55 PM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:40 AM
	06/14/2012 07:30 AM		
<u>Intervention:</u> IPU PRN Medication/FollowUp			
<u>Notes:</u> cont to be restless and difficulty slowing RR down (68); Lorazepam 1mg IV			

Performed On	Document Type	Performed By	Entered On
06/13/2012 10:30 PM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:41 AM
	06/14/2012 07:30 AM		
<u>Intervention:</u> IPU PRN Medication/FollowUp			
<u>Notes:</u> more comfortable; able to speak /s dyspnea; RR 36; medication effective			

Performed On	Document Type	Performed By	Entered On
06/13/2012 10:30 PM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:41 AM
	06/14/2012 07:30 AM		
<u>Intervention:</u> IPU PRN Medication/FollowUp			
<u>Notes:</u> more comfortable; able to speak /s dyspnea; RR 36; medication effective			

Performed On	Document Type	Performed By	Entered On
06/14/2012 12:30 AM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:37 AM
	06/14/2012 07:30 AM		
<u>Intervention:</u> IPU Instruct on disease process			
<u>Notes:</u>			

Performed On	Document Type	Performed By	Entered On
06/14/2012 03:29 AM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:29 AM
	06/14/2012 07:30 AM		
<u>Intervention:</u> IPU SN Perform ESAS			
<u>Notes:</u> chose the incorrect assessment - not completed			

Performed On	Document Type	Performed By	Entered On
06/14/2012 03:29 AM		Frances Stockley RN	
Completed On	Intervention		06/14/2012 03:29 AM
	06/14/2012 07:30 AM		
<u>Intervention:</u> IPU SN Perform ESAS			
<u>Notes:</u> chose the incorrect assessment - not completed			

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient Farr, William G	IPU SOC 06/10/2012	Room	Admit ID 00038311	Patient ID 03570052	LOC
Performed On 06/14/2012 03:30 AM	Document Type		Performed By Frances Stockley RN	Entered On 06/14/2012 03:30 AM	
Completed On	Intervention 06/14/2012 07:30 AM				

Intervention: IPU SN Fall Risk Assessment

Notes:

Performed On 06/14/2012 03:30 AM	Document Type		Performed By Frances Stockley RN	Entered On 06/14/2012 03:30 AM	
Completed On	Assessment 06/14/2012 07:30 AM				

Intervention: IPU SN Fall Risk Assessment

Notes:

Assessment: SRHS IPU Fall Risk Assessment

Observation

Mobility:

Mobility Score

Medication:

Medication Score

Patient has medical condition which could impair their ability to ambulate

Patient has medical condition which could impair their ability to ambulate Score

Total Score

Tier II Low Risk Intervention

Tier II Low Risk Intervention Other

Result

3 - Patient able to move all four extremities and attempts to get out of bed

3

Sedative/hypnotic = 1

Narcotic = 1

Benzodiazepines = 1

3

Chronic debilitating illness = 1

1

7

Post Yellow Leaf

Provide teaching on calling for assistance with transferring or ambulation

Conduct frequent rounding

Other

SR up x 2 at all times; bed in lowest position at all times; room directly across from nsg station; family /c pt at all times

Performed On 06/14/2012 03:30 AM	Document Type		Performed By Frances Stockley RN	Entered On 06/14/2012 03:30 AM	
Completed On	Assessment 06/14/2012 07:30 AM				

Intervention: IPU SN Fall Risk Assessment

Notes:

Assessment: SRHS IPU Fall Risk Assessment

Observation

Mobility:

Result

3 - Patient able to move all four extremities and attempts to get out of bed

Documentation Summary
Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	Mobility Score			3	
	Medication:			Sedative/hypnotic = 1	
				Narcotic = 1	
				Benzodiazepines = 1	
	Medication Score			3	
	Patient has medical condition which could impair their ability to ambulate			Chronic debilitating illness = 1	
	Patient has medical condition which could impair their ability to ambulate Score			1	
	Total Score			7	
	Tier II Low Risk Intervention			Post Yellow Leaf	
				Provide teaching on calling for assistance with transferring or ambulation	
				Conduct frequent rounding	
				Other	
	Tier II Low Risk Intervention Other			SR up x 2 at all times; bed in lowest position at all times; room directly across from nsg station; family /c pt at all times	

Performed On	Document Type	Performed By	Entered On
06/14/2012 03:30 AM		Frances Stockley RN	06/14/2012 03:30 AM
Completed On	Intervention		
	06/14/2012 07:30 AM		

Intervention: IPU SN Fall Risk Assessment
Notes:

Performed On	Document Type	Performed By	Entered On
06/14/2012 03:38 AM		Norma White PCT	06/14/2012 03:38 AM
Completed On	Intervention		
	06/14/2012 03:42 AM		

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)
Notes: no output during shift

Performed On	Document Type	Performed By	Entered On
06/14/2012 06:38 AM		Frances Stockley RN	06/14/2012 07:14 AM
Completed On	Intervention		
	06/14/2012 07:31 AM		

Intervention: IPU SN Shift Summary
Notes: 69 w/m /c lung ca; a/o x3; in good humor with family and staff; O2 at 15 L/M /x oxizimizer; pt has non-rebreather mask but prefers the oxizimer; takes meds whole; at early shift became extremely dyspneic at the beginning of a DuoNeb INH treatment; Morphine 4mg IV given and shortly after Lorazepam given; pt responded well and was able to calm down; HR up to 150's and O2 SaO2 down to 84 on pt's personal pulse oximeter; pt constantly wears his oximeter and focuses on it; pt slept well after receiving Morphine and Lorazepam throughout the night; family at bedside; more understanding of pt's needs and treatment, compassionate care provided

Performed On	Document Type	Performed By	Entered On
06/14/2012 06:38 AM		Frances Stockley RN	06/14/2012 07:14 AM
Completed On	Intervention		
	06/14/2012 07:31 AM		

Documentation Summary
Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Intervention: IPU SN Shift Summary

Notes: 69 w/m /c lung ca; a/o x3; in good humor with family and staff; O2 at 15 L/M /x oxizimizer; pt has non-rebreather mask but prefers the oxizimer; takes meds whole; at early shift became extremely dyspneic at the beginning of a DuoNeb INH treatment; Morphine 4mg IV given and shortly after Lorazepam given; pt responded well and was able to calm down; HR up to 150's and O2 SaO2 down to 84 on pt's personal pulse oximeter; pt constantly wears his oximeter and focuses on it; pt slept well after receiving Morphine and Lorazepam throughout the night; family at bedside; more understanding of pt's needs and treatment, compassionate care provided

Performed On	Document Type	Performed By	Entered On
06/14/2012 07:53 AM		Dorothy Shults RN	06/14/2012 11:05 AM
Completed On	Intervention		
06/14/2012 06:37 PM			

Intervention: IPU PRN Medication/FollowUp

Notes: morphine 4 mg iv and ativan 1 mg iv for dyspnea and anxiety

Performed On	Document Type	Performed By	Entered On
06/14/2012 07:53 AM		Dorothy Shults RN	06/14/2012 11:05 AM
Completed On	Intervention		
06/14/2012 06:37 PM			

Intervention: IPU PRN Medication/FollowUp

Notes: morphine 4 mg iv and ativan 1 mg iv for dyspnea and anxiety

Performed On	Document Type	Performed By	Entered On
06/14/2012 08:00 AM		Dorothy Shults RN	06/14/2012 10:10 AM
Completed On	Intervention		
06/14/2012 06:37 PM			

Intervention: IPU SN Perform Daily Assessment

Notes:

Performed On	Document Type	Performed By	Entered On
06/14/2012 08:00 AM		Dorothy Shults RN	06/14/2012 10:10 AM
Completed On	Assessment		
06/14/2012 06:37 PM			

Intervention: IPU SN Perform Daily Assessment

Notes:

Assessment: SRHS IPU Nursing Assessment Routine 2

Observation

Patient denies pain at this time
Pain Observations

Mental Status
Oriented to

Result

Patient denies pain at this time
Labored breathing
Restlessness
Anxiety
Alert
Person

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	Oriented to			Place	
	Mental Status			Other (specify)	
	Mental Status Other			very anxious	
	Neurological Status			No Significant Findings	
	Patients ability to express self			Requires extra time, reminders or cuing	
	Appetite			Fair	
	Diet			As tolerated	
	Oral Cavity			No significant findings	
	GI Abdomen			Round	
				Soft	
	Bowel Sounds			Active	
	Last bowel movement			06/13/2012	
	GU			No Significant Findings	
	Cardiovascular System			Tachycardia	
				Other (specify)	
	Cardiovascular System Other			nail beds cyanotic at times	
	Peripheral Pulses Weak			Pedal	
	Edema			None noted	
	Breath Sounds			Diminished	
	Pulmonary			Labored	
				O2 Therapy	
	Oximizer L/min			12	
	Pulmonary			Nebulizer treatment	
	Liver			No Significant Findings	
	Bathing			Total care	
	Eating/Oral Care			Partial assist	
	Integument			Warm	
				Dry	
				Flushed	
				Loose	
				Central Line	
				Port accessed	
	Port accessed			Date flushed	
	Port accessed date flushed			06/14/2012	
	Vascular access site location			left chest	
	Vascular Access Site			Benign	
	Patency			Flushes easily	
	Vascular access dressing type			Transparent	
	Vascular access dressing condition			Clean, dry, intact	
	Subcutaneous Access			NA	
	Issues Related to Imminent Death			No issues at present	
	Emotional Status			Anxious	

Performed On
06/14/2012 08:03 AM
Completed On

Document Type

Intervention

06/14/2012 06:45 PM

Performed By
Jamica Mayes PCT

Entered On
06/14/2012 08:03 AM

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)

Notes: T-98.0

P-110

R-16

Documentation Summary
Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

BP-138/82

BKF-50%

LUNCH-PATIENT ATE A TOMATO SANDWICH

DINNER-PATIENT TRAY IS STILL AT THE BEDSIDE

OUTPUT-1X

BM-0

Performed On	Document Type	Performed By	Entered On
06/14/2012 08:27 AM		Dorothy Shults RN	06/14/2012 11:14 AM
Completed On	Intervention		
06/14/2012 06:37 PM			

Intervention: IPU PRN Medication/FollowUpNotes: meds effective, pt resting quietly and is less anxious

Performed On	Document Type	Performed By	Entered On
06/14/2012 08:27 AM		Dorothy Shults RN	06/14/2012 11:14 AM
Completed On	Intervention		
06/14/2012 06:37 PM			

Intervention: IPU PRN Medication/FollowUpNotes: meds effective, pt resting quietly and is less anxious

Performed On	Document Type	Performed By	Entered On
06/14/2012 08:53 AM		Antoinette Sanders MSW	06/14/2012 04:40 PM
Completed On	Intervention		
06/14/2012 05:18 PM			

Intervention: IPU SW Patient Encounter DailyNotes:

Performed On	Document Type	Performed By	Entered On
06/14/2012 10:45 AM		Jamica Mayes PCT	06/14/2012 11:33 AM
Completed On	Intervention		
06/14/2012 06:45 PM			

Intervention: IPU Hospice Aide Patient EncounterNotes:

Performed On	Document Type	Performed By	Entered On
06/14/2012 10:45 AM		Jamica Mayes PCT	06/14/2012 11:34 AM
Completed On	Intervention		
06/14/2012 06:45 PM			

Intervention: IPU Bath: shower or bedbath - pt's preferenceNotes: bedbath refused at this time by the patient

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Performed On	Document Type	Performed By	Entered On
06/14/2012 03:28 PM		Dorothy Shults RN	
Completed On	Intervention		06/14/2012 04:54 PM
	06/14/2012 06:37 PM		

Intervention: IPU PRN Medication/FollowUpNotes: morphine 4 mg iv and ativan 1 mg iv for labored resp and anxiety

Performed On	Document Type	Performed By	Entered On
06/14/2012 03:28 PM		Dorothy Shults RN	
Completed On	Intervention		06/14/2012 04:54 PM
	06/14/2012 06:37 PM		

Intervention: IPU PRN Medication/FollowUpNotes: morphine 4 mg iv and ativan 1 mg iv for labored resp and anxiety

Performed On	Document Type	Performed By	Entered On
06/14/2012 04:00 PM		Dorothy Shults RN	
Completed On	Intervention		06/14/2012 04:54 PM
	06/14/2012 06:37 PM		

Intervention: IPU PRN Medication/FollowUpNotes: meds effective, pt sleeping

Performed On	Document Type	Performed By	Entered On
06/14/2012 04:00 PM		Dorothy Shults RN	
Completed On	Intervention		06/14/2012 04:54 PM
	06/14/2012 06:37 PM		

Intervention: IPU PRN Medication/FollowUpNotes: meds effective, pt sleeping

Performed On	Document Type	Performed By	Entered On
06/14/2012 04:10 PM		David Hutchinson Chaplain	
Completed On	Intervention		06/14/2012 04:12 PM
	06/25/2012 04:31 PM		

Intervention: IPU CH Initial AssessmentNotes: 69 y.o. male transferred in for medication management. Patient is asleep. informatio from sister and daughter.

Performed On	Document Type	Performed By	Entered On
06/14/2012 04:12 PM		David Hutchinson Chaplain	
Completed On	Intervention		06/14/2012 04:12 PM
	06/25/2012 04:31 PM		

Intervention: IPU Provide Spiritual CareNotes: Spiritual needs are met by local Protestant faith community. Pastoral care and presence provided.

Documentation Summary
Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
Performed On	Document Type	Performed By			Entered On
06/14/2012 04:13 PM		David Hutchinson Chaplain			06/14/2012 04:13 PM
Completed On	Intervention				
	06/25/2012 04:31 PM				

Intervention: IPU Conference with NurseNotes: Advised to attend the patient and family by nurse on duty.

Performed On	Document Type	Performed By	Entered On
06/14/2012 04:14 PM		David Hutchinson Chaplain	06/14/2012 04:17 PM
Completed On	Intervention		
	06/25/2012 04:31 PM		

Intervention: IPU CH Shift Summary

Notes: Patient has lung cancer and pulmonary issues. Sisters (2) are in room, one is very attentive to patient and interacting with nursing and support staff. Patient is medicated and unavailable for conversation this visit. Daughter is not fully adjusted to end-of-life issue, expecting a "things to turn around." No immediate need for spiritual care at this time.

Performed On	Document Type	Performed By	Entered On
06/14/2012 04:40 PM		Antoinette Sanders MSW	06/14/2012 04:40 PM
Completed On	Intervention		
	06/14/2012 05:18 PM		

Intervention: IPU Provide Psychosocial counselingNotes:

Performed On	Document Type	Performed By	Entered On
06/14/2012 04:41 PM		Antoinette Sanders MSW	06/14/2012 04:41 PM
Completed On	Intervention		
	06/14/2012 05:18 PM		

Intervention: IPU Provide Psychosocial counselingNotes:

Performed On	Document Type	Performed By	Entered On
06/14/2012 04:41 PM		Antoinette Sanders MSW	06/14/2012 04:42 PM
Completed On	Intervention		
	06/14/2012 05:18 PM		

Intervention: IPU SW Shift Summary

Notes: msw on brief visit with pt at the request of his brother Charles. Pt having more difficulty breathing today. His son Brian also present and engaged msw in conversation regarding his concerns. Dr. Snipes and NP entered the room and addressed their concerns and needs. Pt wears an oximixer which he states bring him comfort. Support and active listening provided.

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
Performed On	Document Type		Performed By	Entered On	
06/14/2012 04:55 PM			Dorothy Shults RN	06/14/2012 04:56 PM	
Completed On	Intervention				
	06/14/2012 06:38 PM				
<u>Intervention:</u> IPU SN Shift Summary					
<u>Notes:</u> pt with lung cancer, labored resp and anxiety early am .medicated with morphine and ativan twice this shift with effective results. uses urinal, appetite poor. family at bedside.					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 04:55 PM			Dorothy Shults RN	06/14/2012 04:56 PM	
Completed On	Intervention				
	06/14/2012 06:38 PM				
<u>Intervention:</u> IPU SN Shift Summary					
<u>Notes:</u> pt with lung cancer, labored resp and anxiety early am .medicated with morphine and ativan twice this shift with effective results. uses urinal, appetite poor. family at bedside.					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 10:15 PM			Carolyn OGrady PCT	06/15/2012 01:51 AM	
Completed On	Intervention				
	06/15/2012 06:24 AM				
<u>Intervention:</u> IPU Hospice Aide Patient Encounter					
<u>Notes:</u>					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 10:38 PM			Frances Stockley RN	06/15/2012 05:13 AM	
Completed On	Intervention				
	06/15/2012 06:40 AM				
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> dyspneic, requesting Morphine; 4mg IV given					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 10:38 PM			Frances Stockley RN	06/15/2012 05:25 AM	
Completed On	Intervention				
	06/15/2012 06:40 AM				
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change					
<u>Notes:</u> dyspneic and requesting Morphine; Morphine 4mg IV given					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 10:38 PM			Frances Stockley RN	06/15/2012 05:13 AM	
Completed On	Intervention				
	06/15/2012 06:40 AM				
<u>Intervention:</u> IPU PRN Medication/FollowUp					

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
<u>Notes:</u> dyspneic, requesting Morphine; 4mg IV given					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 10:38 PM			Frances Stockley RN	06/15/2012 05:25 AM	
Completed On	Intervention				
06/15/2012 06:40 AM					
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change					
<u>Notes:</u> dyspneic and requesting Morphine; Morphine 4mg IV given					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 11:00 PM			Frances Stockley RN	06/15/2012 05:26 AM	
Completed On	Intervention				
06/15/2012 06:40 AM					
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change					
<u>Notes:</u> pt resting and /s c/o; medication effective					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 11:00 PM			Frances Stockley RN	06/15/2012 05:14 AM	
Completed On	Intervention				
06/15/2012 06:40 AM					
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> resting; less anxious; RR down - medication effective					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 11:00 PM			Frances Stockley RN	06/15/2012 05:26 AM	
Completed On	Intervention				
06/15/2012 06:41 AM					
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change					
<u>Notes:</u> pt resting and /s c/o; medication effective					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 11:00 PM			Frances Stockley RN	06/15/2012 05:14 AM	
Completed On	Intervention				
06/15/2012 06:40 AM					
<u>Intervention:</u> IPU PRN Medication/FollowUp					
<u>Notes:</u> resting; less anxious; RR down - medication effective					
Performed On	Document Type		Performed By	Entered On	
06/14/2012 11:50 PM			Carolyn OGrady PCT	06/15/2012 02:09 AM	
Completed On	Intervention				
06/15/2012 06:24 AM					
<u>Intervention:</u> IPU Hospice Aide Patient Encounter					
<u>Notes:</u>					

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Performed On	Document Type	Performed By	Entered On
06/15/2012 01:20 AM		Carolyn OGrady PCT	
Completed On	Intervention		06/15/2012 02:17 AM
06/15/2012 06:24 AM			

Intervention: IPU Hospice Aide Patient Encounter

Notes:

Performed On	Document Type	Performed By	Entered On
06/15/2012 03:12 AM		Carolyn OGrady PCT	
Completed On	Intervention		06/15/2012 03:05 AM
06/15/2012 06:24 AM			

Intervention: IPU Hospice Aide Patient Encounter

Notes:

Performed On	Document Type	Performed By	Entered On
06/15/2012 05:07 AM		Frances Stockley RN	
Completed On	Intervention		06/15/2012 05:08 AM
06/15/2012 06:41 AM			

Intervention: IPU SN Fall Risk Assessment

Notes:

Performed On	Document Type	Performed By	Entered On
06/15/2012 05:07 AM		Frances Stockley RN	
Completed On	Assessment		06/15/2012 05:08 AM
06/15/2012 06:41 AM			

Intervention: IPU SN Fall Risk Assessment

Notes:

Assessment: SRHS IPU Fall Risk Assessment

Observation

Medication:

Medication Score

Patient has medical condition which could impair their ability to ambulate

Patient has medical condition which could impair their ability to ambulate Score

Total Score

Result

Narcotic = 1

Benzodiazepines = 1

2

Chronic debilitating illness = 1

1

3

Performed On	Document Type	Performed By	Entered On
06/15/2012 05:07 AM		Frances Stockley RN	
Completed On	Assessment		06/15/2012 05:08 AM
06/15/2012 06:41 AM			

Intervention: IPU SN Fall Risk Assessment

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Notes:

Assessment: SRHS IPU Fall Risk Assessment

Observation

Medication:

Medication Score

Patient has medical condition which could impair their ability to ambulate

Patient has medical condition which could impair their ability to ambulate Score

Total Score

Result

Narcotic = 1

Benzodiazepines = 1

2

Chronic debilitating illness = 1

1

3

Performed On
06/15/2012 05:07 AM
Completed On

Document Type

Intervention

06/15/2012 06:41 AM

Performed By
Frances Stockley RN

Entered On

06/15/2012 05:08 AM

Intervention: IPU SN Fall Risk Assessment

Notes:

Performed On
06/15/2012 05:15 AM
Completed On

Document Type

Intervention

06/15/2012 06:41 AM

Performed By
Frances Stockley RN

Entered On

06/15/2012 05:24 AM

Intervention: IPU SN Shift Summary

Notes: Pt on 4th day of admission; a/o x3; bedrest due to respiratory depletion; colostomy with soft brown stool, pt emptied and changed wafer without assistance; uses urinal frequently; Lt PAC intact and patent, last date changed 6/10; pt's respiratory status appears slightly improved; O2 at 8-10 L/M oxizimer; INH Albuterol attempted /c pt pulling it off after a few minutes stating it was causing him to "close up" immediately he asked for Morphine; Bi-Pap had been ordered, tried for about 15-20 minutes, pt c/o that the air flow was too great, O2 level decreased, pt wanted the BiPap settings changed and when informed him I would need to have that approved by MD, he just stopped the Bi-Pap and went back to oxizimer; pt has slept well throughout night without distress of any kind; family at bedside and also slept most of the night

Performed On
06/15/2012 05:15 AM
Completed On

Document Type

Intervention

06/15/2012 06:41 AM

Performed By
Frances Stockley RN

Entered On

06/15/2012 05:24 AM

Intervention: IPU SN Shift Summary

Notes: Pt on 4th day of admission; a/o x3; bedrest due to respiratory depletion; colostomy with soft brown stool, pt emptied and changed wafer without assistance; uses urinal frequently; Lt PAC intact and patent, last date changed 6/10; pt's respiratory status appears slightly improved; O2 at 8-10 L/M oxizimer; INH Albuterol attempted /c pt pulling it off after a few minutes stating it was causing him to "close up" immediately he asked for Morphine; Bi-Pap had been ordered, tried for about 15-20 minutes, pt c/o that the air flow was too great, O2 level decreased, pt wanted the BiPap settings changed and when informed him I would need to have that approved by MD, he just stopped the Bi-Pap and went back to oxizimer; pt has slept well throughout night without distress of any kind; family at bedside and also slept most of the night

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
Performed On	Document Type		Performed By	Entered On	
06/15/2012 06:16 AM			Carolyn OGrady PCT	06/15/2012 06:17 AM	
Completed On	Intervention				
06/15/2012 06:24 AM					

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)Notes: 1 bm , emptied colostomy

Performed On	Document Type	Performed By	Entered On
06/15/2012 06:16 AM		Carolyn OGrady PCT	06/15/2012 06:16 AM
Completed On	Intervention		
06/16/2012 05:52 AM			

Intervention: IPU Hospice Aide Patient EncounterNotes:

Performed On	Document Type	Performed By	Entered On
06/15/2012 07:51 AM		Angelene Moore PCT	06/15/2012 08:11 AM
Completed On	Intervention		
06/15/2012 07:03 PM			

Intervention: IPU Hospice Aide Patient EncounterNotes:

Performed On	Document Type	Performed By	Entered On
06/15/2012 08:11 AM		Angelene Moore PCT	06/15/2012 08:12 AM
Completed On	Intervention		
06/15/2012 07:03 PM			

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)Notes:

Performed On	Document Type	Performed By	Entered On
06/15/2012 08:11 AM		Angelene Moore PCT	06/15/2012 08:11 AM
Completed On	Intervention		
06/15/2012 07:03 PM			

Intervention: IPU Fall precaution: Yellow
keep urinal at bedside/ within reachNotes:

Performed On	Document Type	Performed By	Entered On
06/15/2012 09:40 AM		Vickie Tate RN	06/15/2012 09:40 AM
Completed On	Intervention		
06/15/2012 12:40 PM			

Intervention: IPU IV Med Admin/PCA bag change or dose changeNotes:

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient Farr, William G	IPU SOC 06/10/2012	Room	Admit ID 00038311	Patient ID 03570052	LOC
Performed On 06/15/2012 09:40 AM	Document Type		Performed By Vickie Tate RN	Entered On 06/15/2012 09:40 AM	
Completed On	Intervention 06/15/2012 12:40 PM				

Intervention: IPU IV Med Admin/PCA bag change or dose change

Notes:

Performed On 06/15/2012 09:41 AM	Document Type		Performed By Vickie Tate RN	Entered On 06/15/2012 09:41 AM	
Completed On	Intervention 06/15/2012 12:40 PM				

Intervention: IPU SN Perform Daily Assessment

Notes:

Performed On 06/15/2012 09:41 AM	Document Type		Performed By Vickie Tate RN	Entered On 06/15/2012 09:41 AM	
Completed On	Assessment 06/15/2012 12:40 PM				

Intervention: IPU SN Perform Daily Assessment

Notes:

Assessment: SRHS IPU Nursing Assessment Routine 2

Observation

Patient denies pain at this time
Pain Observations

Pain Observations Other

Mental Status
Neurological Status
Patients ability to express self
Appetite
Oral Cavity
GI Abdomen
Ostomy Appliance
Bowel Sounds
Reproductive
Cardiovascular System
Peripheral Pulses
Edema
Breath Sounds
Pulmonary

Oximizer L/min
Pulmonary
Liver

Result

Patient denies pain at this time
Labored breathing
Hyperventilation
Other (specify)
patient has episodes of resp distress more than
pain issues
Alert
No Significant Findings
Express thoughts, feelings, needs w/o difficulty
Fair
No significant findings
Soft
Colostomy
Active
No Significant Findings
Tachycardia
No Significant Findings
None noted
Diminished
Regular
O2 Therapy
15
Nebulizer treatment
No Significant Findings

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	Bathing			Total care	
	Integument			Cool	
				Dry	
	Turgor			WNL	
	Vascular Access Type			Central Line	
				Port accessed	
	Port accessed			Date flushed	
	Port accessed date flushed			06/15/2012	
	Vascular access site location			left PAC	
	Vascular Access Site			Benign	
	Patency			Flushes easily	
				Blood return	
	Vascular access dressing type			Transparent	
	Vascular access dressing condition			Clean, dry, intact	
	Subcutaneous Access			NA	
	Issues Related to Imminent Death			No issues at present	
	Emotional Status			Mood/Affect stable and appropriate	

Performed On	Document Type	Performed By	Entered On
06/15/2012 09:46 AM		Vickie Tate RN	06/15/2012 09:50 AM
Completed On	Intervention		
06/15/2012 12:34 PM			

Intervention: IPU SN Shift Summary

Notes: This is a 69 year old male with lung cancer. He is alert and able to verbalize needs. This patient has episodes of resp. distress. 0745 this shift patient had an episode. Gave Morphine and ativan and taught patient to lean over bedside table to increase airflow. Dr Snipes addressed patients medications and changed some of the resp medication. Patient has a left PAC that is clean and flushes well. He has a colostomy that he cares for. He is continent and he takes his medications whole. Family is by bedside. Will continue to round frequently and assess patients comfort and needs. Emotional support given to patient as well as family.

Performed On	Document Type	Performed By	Entered On
06/15/2012 09:46 AM		Vickie Tate RN	06/15/2012 09:50 AM
Completed On	Intervention		
06/15/2012 12:34 PM			

Intervention: IPU SN Shift Summary

Notes: This is a 69 year old male with lung cancer. He is alert and able to verbalize needs. This patient has episodes of resp. distress. 0745 this shift patient had an episode. Gave Morphine and ativan and taught patient to lean over bedside table to increase airflow. Dr Snipes addressed patients medications and changed some of the resp medication. Patient has a left PAC that is clean and flushes well. He has a colostomy that he cares for. He is continent and he takes his medications whole. Family is by bedside. Will continue to round frequently and assess patients comfort and needs. Emotional support given to patient as well as family.

Performed On	Document Type	Performed By	Entered On
06/15/2012 10:20 AM		Cheri Freeman LBSW	06/15/2012 11:16 AM
Completed On	Intervention		
06/15/2012 11:28 AM			

Intervention: IPU SW Patient Encounter Daily

Notes: routine visit. Pt, spouse and 2 of pts brothers in the room. LBSW conferenced with Dr. Snipes prior to visit.

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines

Sort By Patient

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

LBSW had visited pt at SRMC prior to transfer to Hospice House and pt verbalized that he was feeling better than the last time LBSW saw him and that things are going "slow but sure". Plan at present is for pt to remain in the Hospice House and pt stated that he is agreeable with this at present, feeling better with the care that he has recieved. LBSW provided emotional support and encouragement to pt and family.

Performed On	Document Type	Performed By	Entered On
06/15/2012 11:17 AM		Cheri Freeman LBSW	
Completed On	Intervention		06/15/2012 11:17 AM
	06/15/2012 11:29 AM		

Intervention: IPU SW Shift Summary

Notes: routine visit. Pt, spouse and 2 of pts brothers in the room. LBSW conferenced with Dr. Snipes prior to visit. LBSW had visited pt at SRMC prior to transfer to Hospice House and pt verbalized that he was feeling better than the last time LBSW saw him and that things are going "slow but sure". Plan at present is for pt to remain in the Hospice House and pt stated that he is agreeable with this at present, feeling better with the care that he has recieved. LBSW provided emotional support and encouragement to pt and family.

Performed On	Document Type	Performed By	Entered On
06/15/2012 12:01 PM		Angelene Moore PCT	
Completed On	Intervention		06/15/2012 12:02 PM
	06/15/2012 07:03 PM		

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)

Notes: B 25% 120cc

L 0% 0cc

D 0% 0%

OUTPUT

T 95.2

P 82

R 32

BP 120/90

Performed On	Document Type	Performed By	Entered On
06/15/2012 04:01 PM		Dorothy Shults RN	
Completed On	Intervention		06/15/2012 05:40 PM
	06/15/2012 06:36 PM		

Intervention: IPU PRN Medication/FollowUp

Notes: morphine 2 mg iv and ativan 0.5 mg iv for anxiety and labored resp

Performed On	Document Type	Performed By	Entered On
06/15/2012 04:01 PM		Dorothy Shults RN	
Completed On	Intervention		06/15/2012 05:40 PM
	06/15/2012 06:36 PM		

Intervention: IPU PRN Medication/FollowUp

Notes: morphine 2 mg iv and ativan 0.5 mg iv for anxiety and labored resp

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
Performed On Document Type Performed By Entered On 06/15/2012 04:35 PM Intervention Dorothy Shults RN 06/15/2012 05:41 PM Completed On 06/15/2012 06:36 PM					
<u>Intervention:</u> IPU PRN Medication/FollowUp <u>Notes:</u> meds effective					
Performed On Document Type Performed By Entered On 06/15/2012 04:35 PM Intervention Dorothy Shults RN 06/15/2012 05:41 PM Completed On 06/15/2012 06:36 PM					
<u>Intervention:</u> IPU PRN Medication/FollowUp <u>Notes:</u> meds effective					
Performed On Document Type Performed By Entered On 06/15/2012 05:41 PM Intervention Dorothy Shults RN 06/15/2012 05:42 PM Completed On 06/15/2012 06:36 PM					
<u>Intervention:</u> IPU SN Shift Summary <u>Notes:</u> alert at times, resp labored at times with much anxiety. family hesitant about meds for comfort. appetite poor. family at bedside all shift.					
Performed On Document Type Performed By Entered On 06/15/2012 05:41 PM Intervention Dorothy Shults RN 06/15/2012 05:42 PM Completed On 06/15/2012 06:36 PM					
<u>Intervention:</u> IPU SN Shift Summary <u>Notes:</u> alert at times, resp labored at times with much anxiety. family hesitant about meds for comfort. appetite poor. family at bedside all shift.					
Performed On Document Type Performed By Entered On 06/15/2012 08:53 PM Intervention Frances Stockley RN 06/16/2012 01:56 AM Completed On 06/16/2012 06:18 AM					
<u>Intervention:</u> IPU IV Med Admin/PCA bag change or dose change <u>Notes:</u> c/o tightness in chest and "feeling an attack coming on"; requested Morphine; Morphine 4mg IV Lorazepam 1mg IV					
Performed On Document Type Performed By Entered On 06/15/2012 08:53 PM Intervention Frances Stockley RN 06/16/2012 01:59 AM Completed On 06/16/2012 06:18 AM					

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Intervention: IPU Instruct on other symptom managementNotes: asked by family members about Morphine being given; use of Morphine for dyspnea and air hunger explained

Performed On	Document Type	Performed By	Entered On
06/15/2012 08:53 PM		Frances Stockley RN	
Completed On	Intervention		06/16/2012 01:56 AM
	06/16/2012 06:18 AM		

Intervention: IPU IV Med Admin/PCA bag change or dose changeNotes: c/o tightness in chest and "feeling an attack coming on"; requested Morphine; Morphine 4mg IV Lorazepam 1mg IV

Performed On	Document Type	Performed By	Entered On
06/15/2012 08:53 PM		Frances Stockley RN	
Completed On	Intervention		06/16/2012 01:59 AM
	06/16/2012 06:18 AM		

Intervention: IPU Instruct on other symptom managementNotes: asked by family members about Morphine being given; use of Morphine for dyspnea and air hunger explained

Performed On	Document Type	Performed By	Entered On
06/15/2012 09:00 PM		Frances Stockley RN	
Completed On	Intervention		06/16/2012 02:18 AM
	06/16/2012 06:18 AM		

Intervention: IPU SN Shift SummaryNotes: 4th day of admission, dx: Non-Small Cell lung ca; alert/oriented x 3; bedrest due to exertion; continent of urine; colostomy from previous colon ca patent and maintained by patient; 02 at 8 L/M oxizimer; PAC (L) patent and intact dssg date 6/10; restful at this time; family with pt at all times

Performed On	Document Type	Performed By	Entered On
06/15/2012 09:00 PM		Frances Stockley RN	
Completed On	Intervention		06/16/2012 02:18 AM
	06/16/2012 06:18 AM		

Intervention: IPU SN Shift SummaryNotes: 4th day of admission, dx: Non-Small Cell lung ca; alert/oriented x 3; bedrest due to exertion; continent of urine; colostomy from previous colon ca patent and maintained by patient; 02 at 8 L/M oxizimer; PAC (L) patent and intact dssg date 6/10; restful at this time; family with pt at all times

Performed On	Document Type	Performed By	Entered On
06/15/2012 09:30 PM		Frances Stockley RN	
Completed On	Intervention		06/16/2012 01:58 AM
	06/16/2012 06:18 AM		

Intervention: IPU IV Med Admin/PCA bag change or dose changeNotes: resting comfortably; answers questions appropriately; no dyspnea; medication effective

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient Farr, William G	IPU SOC 06/10/2012	Room	Admit ID 00038311	Patient ID 03570052	LOC
Performed On 06/15/2012 09:30 PM	Document Type		Performed By Frances Stockley RN	Entered On 06/16/2012 01:58 AM	
Completed On	Intervention 06/16/2012 06:18 AM				

Intervention: IPU IV Med Admin/PCA bag change or dose change

Notes: resting comfortably; answers questions appropriately; no dyspnea; medication effective

Performed On 06/15/2012 10:00 PM	Document Type	Performed By Frances Stockley RN	Entered On 06/16/2012 02:04 AM
Completed On	Intervention 06/16/2012 06:18 AM		

Intervention: IPU Family conference

Notes: Received call from SRHS ED staff stating family member, Lisa, at ED requesting patient be transfer there for 2nd opinion. Spoke with pt's son, Brian, whom has been active in pt's care and informed him of call. Brian requested that the request be ignored.

Performed On 06/15/2012 10:00 PM	Document Type	Performed By Frances Stockley RN	Entered On 06/16/2012 02:04 AM
Completed On	Intervention 06/16/2012 06:18 AM		

Intervention: IPU Family conference

Notes: Received call from SRHS ED staff stating family member, Lisa, at ED requesting patient be transfer there for 2nd opinion. Spoke with pt's son, Brian, whom has been active in pt's care and informed him of call. Brian requested that the request be ignored.

Performed On 06/16/2012 12:30 AM	Document Type	Performed By Frances Stockley RN	Entered On 06/16/2012 02:09 AM
Completed On	Intervention 06/16/2012 06:18 AM		

Intervention: IPU Family conference

Notes: Son, Brian, concerned that pt may be receiving too much Morphine and making him sleep. He states pt's brother and sisters are very concerned. Pt's PRN given in last 14 hours discussed. Pt has requested the Morphine when having acute dyspneic episode and received relief within 3-5 minutes. Brian requested that pt only be given 2mg initially and then 2 more if needed. Advised that we would consider this but give the amount pt requested. Family concerned that pt sleeps too much. The exhaustion of dyspnea explained and the pt's need for increased rest as condition declines.

Performed On 06/16/2012 12:30 AM	Document Type	Performed By Frances Stockley RN	Entered On 06/16/2012 02:09 AM
Completed On	Intervention 06/16/2012 06:18 AM		

Intervention: IPU Family conference

Notes: Son, Brian, concerned that pt may be receiving too much Morphine and making him sleep. He states pt's brother and sisters are very concerned. Pt's PRN given in last 14 hours discussed. Pt has requested the Morphine when

Documentation Summary**Spartanburg Regional Hospice Home****Sort By Patient****All Disciplines****Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

having acute dyspneic episode and received relief within 3-5 minutes. Brian requested that pt only be given 2mg initially and then 2 more if needed. Advised that we would consider this but give the amount pt requested. Family concerned that pt sleeps too much. The exhaustion of dyspnea explained and the pt's need for increased rest as condition declines.

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:54 AM		Frances Stockley RN	06/16/2012 01:54 AM
Completed On	Intervention		
	06/16/2012 06:19 AM		

Intervention: IPU SN Fall Risk AssessmentNotes:

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:54 AM		Frances Stockley RN	06/16/2012 01:54 AM
Completed On	Intervention		
	06/16/2012 06:19 AM		

Intervention: IPU SN Fall Risk AssessmentNotes:

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:54 AM		Frances Stockley RN	06/16/2012 01:54 AM
Completed On	Assessment		
	06/16/2012 06:19 AM		

Intervention: IPU SN Fall Risk AssessmentNotes:Assessment: SRHS IPU Fall Risk AssessmentObservation

Medication:

Medication Score

Patient has medical condition which could impair their ability to ambulate

Patient has medical condition which could impair their ability to ambulate Score

Total Score

Result

Narcotic = 1

Benzodiazepines = 1

2

Chronic debilitating illness = 1

1

3

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:54 AM		Frances Stockley RN	06/16/2012 01:54 AM
Completed On	Assessment		
	06/16/2012 06:19 AM		

Intervention: IPU SN Fall Risk AssessmentNotes:Assessment: SRHS IPU Fall Risk AssessmentObservation

Medication:

Result

Narcotic = 1

Benzodiazepines = 1

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	Medication Score			2	
	Patient has medical condition which could impair their ability to ambulate			Chronic debilitating illness = 1	
	Patient has medical condition which could impair their ability to ambulate Score			1	
	Total Score			3	

Performed On	Document Type	Performed By	Entered On
06/16/2012 02:21 AM		Frances Stockley RN	06/16/2012 02:21 AM
Completed On	Intervention		
06/16/2012 06:19 AM			

Intervention: IPU SN Shift Summary

Notes: awake requesting coffee and orange juice; has slept since 2200 prior to this

Performed On	Document Type	Performed By	Entered On
06/16/2012 02:21 AM		Frances Stockley RN	06/16/2012 02:21 AM
Completed On	Intervention		
06/16/2012 06:19 AM			

Intervention: IPU SN Shift Summary

Notes: awake requesting coffee and orange juice; has slept since 2200 prior to this

Performed On	Document Type	Performed By	Entered On
06/16/2012 05:37 AM		Carolyn OGrady PCT	06/16/2012 05:37 AM
Completed On	Intervention		
06/16/2012 05:52 AM			

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)

Notes: one urine out

Performed On	Document Type	Performed By	Entered On
06/16/2012 05:55 AM		Frances Stockley RN	06/16/2012 05:57 AM
Completed On	Intervention		
06/16/2012 06:19 AM			

Intervention: IPU SN Shift Summary

Notes: slept throughout the night from 2100 until 0500; awoke feeling fresh; stated "that is the best sleep I have had in months". no dyspnea; O2 cont; states he emptied his colostomy on late evening; used urinal with yellow urine - amt not measured, no dyspnea episodes this shift, family at bedside throughout the night

Performed On	Document Type	Performed By	Entered On
06/16/2012 05:55 AM		Frances Stockley RN	06/16/2012 05:57 AM
Completed On	Intervention		
06/16/2012 06:19 AM			

Intervention: IPU SN Shift Summary

Notes: slept throughout the night from 2100 until 0500; awoke feeling fresh; stated "that is the best sleep I have had in months". no dyspnea; O2 cont; states he emptied his colostomy on late evening; used urinal with yellow urine - amt not measured, no dyspnea episodes this shift, family at bedside throughout the night

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
Performed On	Document Type		Performed By	Entered On	
06/16/2012 07:44 AM			Angelene Moore PCT	06/16/2012 07:45 AM	
Completed On	Intervention				
	06/16/2012 06:48 PM				

Intervention: IPU Hospice Aide Shift Summary (V/S, I/O, percentage of meals, number BMs)

Notes: T 96.6

P 108

R 34

BP 120/70

B

L

D

OUTPUT

Performed On	Document Type	Performed By	Entered On
06/16/2012 08:00 AM		Debra Strevel RN	06/16/2012 08:03 AM
Completed On	Assessment		
	06/16/2012 01:33 PM		

Intervention: IPU SN Admission Assessment

Notes:

Assessment: SRHS IPU Nursing Assessment - Admission

Performed On	Document Type	Performed By	Entered On
06/16/2012 08:00 AM		Debra Strevel RN	06/16/2012 08:03 AM
Completed On	Assessment		
	06/16/2012 01:33 PM		

Intervention: IPU SN Perform Daily Assessment

Notes:

Assessment: SRHS IPU Nursing Assessment Routine 2

Observation

Patient denies pain at this time

Pain Observations

Mental Status

Oriented to

Neurological Status

Patients ability to express self

Appetite

Nutrition/Hydration

Diet

Oral Cavity

GI Abdomen

Result

Patient denies pain at this time

Labored breathing

No non-verbal signs of pain

Alert

Person

Place

Time

No Significant Findings

Express thoughts, feelings, needs w/o difficulty

Poor

Anorexia

As tolerated

No significant findings

Flat

Documentation Summary
Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	
	GI Abdomen			Soft	
	Ostomy Appliance			Colostomy	
	Bowel Sounds			Active	
	Last bowel movement			06/15/2012	
	GU			No Significant Findings	
	Peripheral Pulses Weak			Pedal	
	Edema			None noted	
	Breath Sounds			Diminished	
				Rales	
				Rhonci	
	Pulmonary			Labored	
				Dyspnea	
				O2 Therapy	
				10	
	Oximizer L/min			BiPAP	
	Pulmonary			No Significant Findings	
	Liver			Partial assist	
	Bathing			Warm	
	Integument			Dry	
				Loose	
	Turgor			Implanted Device (Port, etc)	
	Vascular Access Type			Port accessed	
				left chest	
	Vascular access site location			Benign	
	Vascular Access Site			Flushes easily	
	Patency			Transparent	
	Vascular access dressing type			Clean, dry, intact	
	Vascular access dressing condition			NA	
	Subcutaneous Access			No issues at present	
	Issues Related to Imminent Death			Mood/Affect stable and appropriate	
	Emotional Status				

Performed On
06/16/2012 08:00 AM
Completed On

Document Type

Performed By
Debra Strevel RN

Entered On

06/16/2012 08:03 AM

Intervention

06/16/2012 01:33 PM

Intervention: IPU SN Perform Daily Assessment

Notes:

Performed On
06/16/2012 08:00 AM
Completed On

Document Type

Performed By
Debra Strevel RN

Entered On

06/16/2012 08:03 AM

Intervention

06/16/2012 01:33 PM

Intervention: IPU SN Admission Assessment

Notes:

Performed On
06/16/2012 01:00 PM
Completed On

Document Type

Performed By
Ashleigh Pintoff RN

Entered On

06/16/2012 01:21 PM

Intervention

06/16/2012 03:03 PM

Documentation Summary
Spartanburg Regional Hospice Home
All Disciplines **Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM**

Sort By Patient

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Intervention: IPU SN Patient Encounter Discharge AliveNotes:

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:21 PM		Ashleigh Pintoff RN	
Completed On	Intervention		06/16/2012 01:21 PM
	06/16/2012 03:03 PM		

Intervention: IPU Provide patient report to receiving facility if applicableNotes: notified hosice care of SC

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:21 PM		Ashleigh Pintoff RN	
Completed On	Intervention		06/16/2012 01:21 PM
	06/16/2012 03:03 PM		

Intervention: IPU Complete discharge formsNotes:

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:21 PM		Ashleigh Pintoff RN	
Completed On	Intervention		06/16/2012 01:21 PM
	06/16/2012 03:03 PM		

Intervention: IPU Provide discharge instructionsNotes: to son, Brian Farr

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:22 PM		Ashleigh Pintoff RN	
Completed On	Intervention		06/16/2012 01:22 PM
	06/16/2012 03:03 PM		

Intervention: IPU SN Shift SummaryNotes: please see nursing daily shift summary

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:22 PM		Ashleigh Pintoff RN	
Completed On	Intervention		06/16/2012 01:22 PM
	06/16/2012 03:03 PM		

Intervention: IPU SN Shift SummaryNotes: please see nursing daily shift summary

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:22 PM		Ashleigh Pintoff RN	
Completed On	Intervention		06/16/2012 01:22 PM
	06/16/2012 03:03 PM		

Documentation Summary

Spartanburg Regional Hospice Home

Sort By Patient

All Disciplines

Dates: 06/07/12 12:00 AM to 08/27/13 11:59 PM

Patient	IPU SOC	Room	Admit ID	Patient ID	LOC
Farr, William G	06/10/2012		00038311	03570052	

Intervention: IPU SN Shift SummaryNotes: please see nursing daily shift summary

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:27 PM		Debra Strevel RN	
Completed On	Intervention		06/16/2012 01:32 PM
	06/16/2012 01:33 PM		

Intervention: IPU SN Shift Summary

Notes: DX: lung ca with hx colon ca--GIP. Pt had "episode" early shift of severe dyspnea, medicated with morphine and ativan with good relief achieved.....family continues to question actions of staff re: meds and pt's care. This RN is uncomfortable with family interference in providing appropriate care for pt's distressing sx of dyspnea and sensation of "smothering"

Discussed d/c home with pt/family. Son, Brian, spoke with Dr Snipes by phone and decision is made to transfer care to Hospice Care of SC and d/c home this afternoon.

C2 rx's faxed to OP pharmacy (SRHS) and reg meds called in to OP pharmacy.

Reviewed d/c instructions and med rec with Brian

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:27 PM		Debra Strevel RN	
Completed On	Intervention		06/16/2012 01:32 PM
	06/16/2012 01:33 PM		

Intervention: IPU SN Shift Summary

Notes: DX: lung ca with hx colon ca--GIP. Pt had "episode" early shift of severe dyspnea, medicated with morphine and ativan with good relief achieved.....family continues to question actions of staff re: meds and pt's care. This RN is uncomfortable with family interference in providing appropriate care for pt's distressing sx of dyspnea and sensation of "smothering"

Discussed d/c home with pt/family. Son, Brian, spoke with Dr Snipes by phone and decision is made to transfer care to Hospice Care of SC and d/c home this afternoon.

C2 rx's faxed to OP pharmacy (SRHS) and reg meds called in to OP pharmacy.

Reviewed d/c instructions and med rec with Brian

Performed On	Document Type	Performed By	Entered On
06/16/2012 01:27 PM		Debra Strevel RN	
Completed On	Intervention		06/16/2012 01:32 PM
	06/16/2012 01:33 PM		

Intervention: IPU SN Shift Summary

Notes: DX: lung ca with hx colon ca--GIP. Pt had "episode" early shift of severe dyspnea, medicated with morphine and ativan with good relief achieved.....family continues to question actions of staff re: meds and pt's care. This RN is uncomfortable with family interference in providing appropriate care for pt's distressing sx of dyspnea and sensation of "smothering"

Discussed d/c home with pt/family. Son, Brian, spoke with Dr Snipes by phone and decision is made to transfer care to Hospice Care of SC and d/c home this afternoon.

C2 rx's faxed to OP pharmacy (SRHS) and reg meds called in to OP pharmacy.

Reviewed d/c instructions and med rec with Brian

☐ SRMC ☐ SHRC ☐ VH

DATE/TIME	NOTES
06/12/14	<u>ADMIT NOTE - 1st & DICTATED</u> 69 Y.O. MAN - CHRONIC LEFT PNEUMOTHORAX DUE TO - (1) LT COPD (2) SP BILOBAR RESECTION (3) LUNG PROBABLE BLUNT LUMBAR TRANSVERSE CT HYPERCLASTIC 4 (LUMBAR). PPS-307 PLAN: (1) SA MONITORING (2) CONT LOW BURDEN MED INTERVENTION. (3) Home & Home HOUSING 1K ABLE (4) GOC DISCT PM, PAINLY "I WANT TO BE COMFORTABLE" Correct. <i>[Signature]</i>

1216401412 000 478884 08/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E

1080 (Rev

Physician Progress Note

SPARTANBURG REGIONAL HOSPICE HOME

Date: 06/12/12 Time: 12 PM

S:

INITIALLY BETTER NO DYSPNOEA AND
THEN BECAME PROFOUNDLY
DYSPNOEIC P STANDING

Breakthrough doses:

Activity: Intake:
O: Physical exam: Vital signs 97.7 - 128 - 38 - 128/64 ☐ Unremarkable
General: No distress / comfortable / mod distress / severe distress
Mental status: Alert / lethargic / obtunded / agitated / SAS ANXIETY / DYSPNOEA
HEENT: MMs moist/dry
Neck: JVD
Lungs: CTA / diminished / rales / wheeze / upper airway congestion
Cardiac: RRR / tachycardia / irregular
Abd: Soft / distended / tender / BS pres/abs
Extremities: Edema
Neuro:
Other:

A: Assessment

Hospice diagnosis

Other

//P: Plans--

A/C NEAR PULMONO DIS COPO/
LUNG REACTION/
INTERMITTENT PLEURAL
VS. CP

- REVERS EXacerbation of DYSPNOEA
→ PRN PNEUMS, LONGTERM, MONITORING ON
RELIEF PR.

☒ Family counseling:

UPDATE TO FAMILY BYRON, DAWSON

PPS: 30-20 Prognosis:

? DAYS TO SEVERE W/ (COULD DIE AT
ANY TIME)Reason for GIF (if applicable): ☐ Symptom management. What symptoms/how?☐ Other:Disposition: ☒ Active management ☐ Possible D/C if stabilizes ☐ Planning discharge

Signature:

Garrett Snipes
☐ Garrett Snipes, MD ☐ Brian Bell, MD
☐ Robert Houston, MD ☐ Sam Gacha, MD

1216401412 000 478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E



Physician Progress Note

SPARTANBURG REGIONAL HOSPICE HOME

Date: 06/12/12 Time: _____

S: _____

INTERMITTENTLY VERY DYSPNEIC.
THIS MORNING REPORTABLY COMFORTABLE
BUT WORK - USING NECESSARY MUSCLES
OF VENTILATION.

Breakthrough doses:

Activity: B.A. Intake: F.M.P.
O: Physical exam: Vital signs 200-110-16-135/92 ☐ Unremarkable
General: No distress / comfortable / ~~mod distress~~ / severe distress
Mental status: Alert / lethargic / obtunded / agitated / SAS
HEENT: MMs moist/dry
Neck: JVD
Lungs: CTA / diminished / rales / wheeze / upper airway congestion
Cardiac: RRR / tachycardia / irregular
Abd: Soft / distended / tender / BS pres/abs
Extremities: Edema
Neuro: _____
Other: _____

A: Assessment

Hospice diagnosis

Other

SEVERE COPD / CHRONIC RESPIRATORY
* PULMONARY HYPERTENSION
* DYSPNOEA : INTERMITTENT RESPIRATORY
EXacerbation

→ ADULT HOUSING / Palliative of Dyspnea
TMA B.I.M.

☒ Family counseling:

SON BRIAN / BROTHER.

PPS: 20 Prognosis:

POOR TO MODERATE - ADVANCE DEMENTIA

Reason for GIP (if applicable): ☐ Symptom management. What symptoms/how?:

DYSPNOEA

☐ Other:Disposition: ☒ Active management ☐ Possible D/C if stabilizes ☐ Planning discharge

Signature: _____

☐ Garrett Snipes, MD ☐ Brian Bell, MD
☐ Robert Houston, MD ☐ Sam Gacha, MD

1216401412 000478684 06/12/12
FARR, WILLIAM G
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E



Physician Progress Note

SPARTANBURG REGIONAL HOSPICE HOME

Date: 06/18/12 Time: _____

S: _____

DYSPNOEA AT REST BUT NOT DISTRESSED
 WEDIC. GETTING WEDICER
 EPISODE OF PROFOUND DYSPNOEA - 2
 MUCOX. PLUG

Breakthrough doses:

Activity: BRIntake: + 1500O: Physical exam: Vital signs 95.2 - 92 - 120/50 ☐ UnremarkableGeneral: No distress / comfortable / not distress / severe distressMental status: Alert / lethargic / obtunded / agitated / SASHEENT: Mucous membranesNeck: JVDLungs: CTA / diminished / rales / wheeze / upper airway congestionUSING NEBULIZERCardiac: RRR / tachycardic / irregularAbd: Soft / distended / tender / BS pres/absExtremities: Edema

Neuro: _____

Other: _____

A: Assessment

Hospice diagnosis

Other: _____

P: Plans

ES COPDCHRONIC RECR. PULMONARYPROB. RECURRENT
LUNG
CANCERDYSPNOEACHRONICALLY DECLINING→ ① PT. DOES WANT CARE AT HH, DESPITE FAMILY
REFERRAL VISION② AS TO MDD: - FOR TRAINER HOW MANY
WEEKS OF DYSPNOEA☐ Family counseling: ③ PLAN B. FOR - OF 10/18/12 AND TO DYSPNOEAPPS: 200 Prognosis: 2 WK TO 1 WKReason for GIP (if applicable): ☒ Symptom management. What symptoms/how?:☐ Other: _____Disposition: ☐ Active management ☐ Possible D/C if stabilizes ☐ Planning dischargeSignature: Garrett Snipes☐ Garrett Snipes, MD ☐ Brian Bell, MD☐ Robert Houston, MD ☐ Sam Gacha, MD

1216401412 000-478684 06/12/12
 FARR, WILLIAM G M 69Y
 ADM: SNIPES, GARRETT E
 REF: SNIPES, GARRETT E





SPARTANBURG
Regional Healthcare System

☐ SRMC

☐ SHRC

☐ VH

PROGRESS NOTES

DATE/TIME	NOTES
06/16/12	S: SOB (+) wearing O ₂ maximizer
11:10	O: VS stable Afebrile
	CV: HND
	Chest: Rale (+) crackles (+)
	Ad B (+) Soft.
	A/P
	(1) ZSCOPD
	(2) Chronic resp failure
	Plan: wife @ bedside / w family. By RN family has been difficult to deal.
	PPS 10-20%
	Denies Pain
	SBACH, MD
06/17/12	D/C Summary dictated
	1259443
	SBACH, MD

P2

1216401412 000-478684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REF: SNIPES, GARRETT E



1080 (Rev. 1)



Discharged

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

DOB: [REDACTED]

SOC: 06/07/2012

Spartanburg Regional Hospice

120 Heywood Ave

Suite 300

Spartanburg, SC 293021211

8645603900

Contains

SRHS Discharge Summary

Hospice IDG Careplan 3 Non-Visit

Hospice IDG Careplan 3 Discharge Non-Death

Date In: 6/16/2012 5:42:00PM

Date Out: 6/16/2012 8:34:00PM

Personnel: Shelton, Sarah RN

SRHS Discharge SummaryClinical Record Items

Discharge Summary

Patient ID Number

Start of Care Date

Patient Name

Patient State of Residence

Patient Zip Code

Admission Condition

Discharge Date:

Last Visit Date

Discharge Discipline

Disciplines Provided:

Reason for discharge

Advance Directives:

Power of Attorney (specify name):

Orders Regarding End of Life Decisions:

Discharge Diagnosis - Primary

Primary ICD9

Primary Exacerbation Date

Discharge Diagnosis Secondary

Agency Discharge

00038224

06/07/2012

Farr William G

SC

29379

Guarded

06/16/2012

06/08/2012

SN

MSW

HHA

SN

MSW

HHA

Transferred to another agency

1- DNR

2- Living Will

Power of Attorney (specify name):

Brian Farr

Comfort measures only

MALIGNANT NEOPLASM OF BRONCHUS AND LUNG,
UNSPECIFIED

1629

05/31/2012

OBSTRUCTIVE CHRONIC BRONCHITIS WITH (ACUTE)
EXACERBATION

Created: 6/18/2012 5:42:00PM

Completed: 6/21/2012 8:35:00PM

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Page 1 of 9



Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Discharge Diagnosis Secondary:

UNSPECIFIED ESSENTIAL HYPERTENSION
HYPOPOTASSEMIA
OTHER AND UNSPECIFIED HYPERLIPIDEMIA

Secondary ICD9

49121

Secondary Exacerbation Date

05/31/2012

Secondary ICD9

4019

Secondary Exacerbation Date

05/31/2012

Secondary ICD9

2768

2724

Secondary Exacerbation Date

05/31/2012

Overall Status:

2- Stablized

Systolic Blood Pressure (1)

118

Diastolic Blood Pressure (1)

82

Pulse (1)

120

Respirations

28

Oxygen O2 Flow Rate (LPM)

6

Temperature

96.5

Created: 6/18/2012 5:42:00PM

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Page 2 of 9



Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Medications:

*** AMBIEN 10 mg TABLET 1 ORAL Bedtime
Begin: 06/07/2012
Coverage: Provider
*** ATIVAN 1 mg TABLET 1-2 ORAL Every 4 hours as needed
Begin: 06/07/2012
Coverage: Provider
*** KLOR-CON M20 20 mEq TAB ER PRT 2 ORAL 2 times daily
Begin: 06/07/2012
*** moxifloxacin 400mg tablet 1 ORAL Daily
Begin: 06/07/2012
*** NORCO 10 mg-325 mg TABLET 1-2 ORAL Every 4 hours as needed
Begin: 06/07/2012
*** OMEPRAZOLE 20 mg TABLET DR 1 ORAL 2 times daily
Begin: 06/07/2012
Coverage: Patient
*** PREDNISON 20 mg TABLET 1 ORAL 3 times daily
Begin: 06/07/2012
Coverage: Provider
*** PROAIR HFA 90 mcg HFA AER AD 2 puffs INHALATION As needed
Begin: 06/07/2012
Coverage: Provider
*** PROVENTIL 90 mcg AER REFILL 2 puffs INHALATION Every 6 hours as needed
Begin: 06/07/2012
Coverage: Provider
*** ROXANOL 20 mg/mL SOLUTION 0.25-0.5 ORAL Every 2 to 3 hours as needed
Begin: 06/07/2012
Coverage: Provider
Order Note: New order for 06/07/2012
ROXANOL 20 mg/mL SOLUTION
0.25-0.5 ORAL Every 2 to 3 hours as needed
Coverage: Provider
*** SIMVASTATIN 40 mg TABLET 1 ORAL Bedtime
Begin: 06/07/2012
Coverage: Patient
*** TRIAMTERENE W/HCTZ 37.5-25MG TABLET 1 ORAL Daily
Begin: 06/07/2012
Coverage: Patient

Summary of Discipline - SN

1-Self care education
2-Medication management
4-Symptom management
8-Other (specify)

Summary of Discipline - SN other

emotional support

Summary of Discipline - MSW

1-Evaluation

Summary of Discipline - MSW other

6-Other (specify)

Summary of Discipline - HHA

Emotional support

Summary of Discipline - HHA other

1-Personal care

Emotional support

Created: 6/18/2012 5:42:00PM

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Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Patient	1-Demonstrates knowledge of disease process including expected course/prognosis
Caregiver	1-Demonstrates knowledge of disease process including expected course/prognosis
Patient	2-Skin intact with no indication of infection
Caregiver	3-Pain relieved or controlled within acceptable limits
	4-Describes signs and symptoms to report to MD
	5-Verbalizes appropriate emergency response measures
	6-Describes the purpose/action and side effects of all medications
Patient	7-Demonstrates compliance with medication schedule
Caregiver	7-Demonstrates compliance with medication schedule
Patient	8-No signs and/or symptoms of adverse effects of medication evident
	9- Compliant with prescribed diet including any restrictions
	10-Maintains adequate intake of fluid and calories
	11-ADL needs met either independently or with assistance
Caregiver	13-Complies with safety measures implemented to reduce risk of falls/injury
	14-Performs therapeutic procedures correctly
	15-Complies with infection control measures including disposal of medical waste
	16-Demonstrates safe use of DME
	17-Demonstrates effective coping skills
	18-Uses available community resources effectively
Other Progress toward Goals/Other Outcomes Achieved:	Initial Hospice Plan of Care Physician: Mehta, Sharmila Pravin MD Cert Period Starts: 06/07/2012 Cert Period Ends: 09/04/2012 Problems: EXPECTED OUTCOMES
	Plans: Verbalizes correct medication/supplement schedule or has written schedule for reference. Verbalizes hospice protocol. Verbalizes plan of care and hospice services. Verbalizes how and when to contact hospice staff. Patient verbalizes/demonstrates effective level of pain and/or symptom control Verbalizes primary concern and personal goals for care. Verbalizes measures to ensure personal safety. Pt/Cg verbalizes disease progression: s/sx dying, potential for skin breakdown, urinary incontinence, decreased desire/ability to eat/drink and alternative treatment measures to increase comfort.
Notification of Service Termination:	2-Physician 3-Pharmacy 4-HME provider 5-Other (specify): Hospice staff
Notification of Service Termination - Other:	
Notes:	Patient transferred to another Hospice agency

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Hospice Pre Post Patient Activity (Visit 06/16/2012)



1593112194

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Clinician Diagnoses

<u>Resolved</u>	<u>Description</u>
06/18/2012	Physical/symptom issues: pain, delirium, cognitive impairments, dyspnea, cough, wound, nausea, vomiting, anorexia, bladder incontinence, bowel incontinence, constipation, diarrhea, immobility, self-care deficit __
06/18/2012	Psychosocial/emotional issues: agitation, anxiety, depression, stress, anticipatory grieving, denial, anger, ineffective coping, intimacy, self image, limited support system, substance abuse, mental illness __
06/18/2012	Caregiver issues: anxiety, depression, anticipatory grieving, burden of care, limited support system, physical limitations, substance abuse, mental illness __
06/18/2012	Functional/Safety issues: immobility, self-care deficit__
06/18/2012	Spiritual issues: altered access to faith/spiritual community, alteration in spiritual practices, altered belief system, altered life's meaning, need for closure, spiritual distress __
06/18/2012	Family/support issues: family conflict, communication, lack of resources, child/teen grief, role reversal, finances, inadequate housing __
06/18/2012	OXYGEN Use/Safety
06/18/2012	Palliative/Hospice Disease Management
06/18/2012	PAIN MANAGEMENT
06/18/2012	Symptom Management
06/18/2012	Fall/Safety Risk Prevention
06/18/2012	Nutrition - End of Life

Grouped Clinician Diagnosis: Caregiver issues: anxiety, depression, anticipatory grieving, burden of care, limited support system, physical limitations, substance abuse, mental illness __

Interventions

Intervention Category:	PSYCHOSOCIAL/SPIRITUAL/CULTURAL	Identified: 06/07/2012	Achieved:					
<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>	
06/18/2012	Evaluate need for respite care and/or volunteer services; instruct on available services.	N	N				N	

Grouped Clinician Diagnosis: Functional/Safety issues: immobility, self-care deficit__

Interventions

Intervention Category:	SAFETY	Identified: 06/07/2012	Achieved:					
<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>	

Created: 6/18/2012 5:42:00PM

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Hospice Pre Post Patient Activity (Visit 06/16/2012)



1593112194

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

06/18/2012	Instruct on principles of Standard Precautions: proper handling/disposal of items coming in contact with body fluids.	N	N					N
06/18/2012	Instruct on safe use, care, storage, and disposal of equipment, supplies and medications.	N	N					N

Grouped Clinician Diagnosis: Not Associated

Interventions

Intervention Category:	NURSE CLINICAL SUMMARY	Identified:	06/07/2012	Achieved:				
	<u>Achieved</u> <u>Interventions</u> <u>Performed</u> <u>Var</u> <u>Var Type</u> <u>Rsn Code</u> <u>Act Cod</u> <u>Move to Next Visit</u>							
06/18/2012	Enter a summary of the NURSE Visit in the NOTE BOX. Include items that may require follow up. Background required on Admission clinical summary. Note: Transferred to another agency.	Y	N					N

Grouped Clinician Diagnosis: Nutrition - End of Life

Problems

Problem:	EXPECTED OUTCOMES	Identified:	06/07/2012	Achieved:				
	<u>Target</u> <u>Achieved</u> <u>Outcomes</u> <u>Var</u> <u>Var Type</u> <u>Rsn Code</u> <u>Act Cod</u>							
06/18/2012	Pt/Cg verbalizes disease progression: s/sx dying, potential for skin breakdown, urinary incontinence, decreased desire/ability to eat/drink and alternative treatment measures to increase comfort.		N					

Grouped Clinician Diagnosis: Palliative/Hospice Disease Management

Interventions

Intervention Category:	HOSPICE SERVICES	Identified:	06/07/2012	Achieved:				
	<u>Achieved</u> <u>Interventions</u> <u>Performed</u> <u>Var</u> <u>Var Type</u> <u>Rsn Code</u> <u>Act Cod</u> <u>Move to Next Visit</u>							
06/18/2012	Verify Medicare Notice of Non Coverage is completed at least 2 days prior to discharge if discharge is not due to death, revocation, or transfer.	N	N					N
06/18/2012	Discuss and obtain signatures on discharge forms as appropriate, Hospice Transfer or Hospice Revocation.	N	N					N
06/18/2012	Instruct on discharge items, resumption of traditional Medicare benefits and re election of Hospice benefit.	N	N					N

Intervention Category:	INTERTEAM SERVICES/COMMUNITY REFERRALS	Identified:	06/07/2012	Achieved:				
	<u>Achieved</u> <u>Interventions</u> <u>Performed</u> <u>Var</u> <u>Var Type</u> <u>Rsn Code</u> <u>Act Cod</u> <u>Move to Next Visit</u>							

Created: 6/18/2012 5:42:00PM

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Hospice Pre Post Patient Activity (Visit 06/16/2012)



1593112194

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

06/18/2012	Coordinate services for medications, medical equipment and supplies, medical services, and community resources.	N	N					N
06/18/2012	Assess ability to purchase necessary supplies, food, etc., needed for treatment.	N	N					N
06/18/2012	Coordinate services with receiving hospice if transferring.	N	N					N
06/18/2012	Evaluate need for assistance with funeral planning.	N	N					N
06/18/2012	Discuss any changes in patient condition and plan to discharge from Hospice with caregiver/facility staff.	N	N					N
06/18/2012	Coordinate/Provide copy of Hospice careplan	N	N					N

Intervention
Category:

DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

Achieved	Interventions	Performed	Var	Var Type	Rsn Code	Act Cod	Move to Next Visit
06/18/2012	Provide signed DNR order to be placed in home.	N	N				N

Problems

Problem:

EXPECTED OUTCOMES

Identified: 06/07/2012 Achieved:

Target	Achieved	Outcomes	Var	Var Type	Rsn Code	Act Cod
06/18/2012		Verbalizes plan to obtain equipment, supplies, medications and lab tests.	N			
06/18/2012		Verbalizes hospice protocol.	N			
06/18/2012		Verbalizes importance of follow-up visits with physician and other services.	N			
06/18/2012		Verbalizes plan of care and hospice services.	N			
06/18/2012		Verbalizes how and when to contact hospice staff.	N			
06/18/2012		Patient verbalizes/demonstrates effective level of pain and/or symptom control	N			
06/18/2012		Verbalizes primary concern and personal goals for care.	N			
06/18/2012		Verbalizes measures to ensure personal safety.	N			

Grouped Clinician Diagnosis: Physical/symptom issues: pain, delirium, cognitive impairments, dyspnea, cough, wound, nausea, vomiting, anorexia, bladder incontinence, bowel incontinence, constipation, diarrhea, immobility, self-care deficit __

InterventionsIntervention
Category:

DISEASE AND SYMPTOM

Identified: 06/07/2012 Achieved:

Created: 6/18/2012 5:42:00PM

Printed: 8/26/2013 11:10:06AM

Completed: 6/21/2012 8:35:00PM

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Hospice Pre Post Patient Activity (Visit 06/16/2012)



1593112194

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
06/18/2012	Assess for medication effectiveness/symptom control; side effects and compliance.	N	N				N
06/18/2012	Instruct on medication/supplement; purpose, action, and side effects.	N	N				N
06/18/2012	Evaluate need/effectiveness/safety of equipment/supplies; initiate order as needed; instruct as needed	N	N				N

Problems

Problem: EXPECTED OUTCOMES

Identified: 06/07/2012 Achieved:

<u>Target</u>	<u>Achieved</u>	<u>Outcomes</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>
06/18/2012		Verbalizes correct medication/supplement schedule or has written schedule for reference.	N			

Grouped Clinician Diagnosis: Psychosocial/emotional issues: agitation, anxiety, depression, stress, anticipatory grieving, denial, anger, ineffective coping, intimacy, self image, limited support system, substance abuse, mental illness __

Problems

Problem: EXPECTED OUTCOMES - Spiritual/Chaplain

Identified: 06/07/2012 Achieved:

<u>Target</u>	<u>Achieved</u>	<u>Outcomes</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>
By Discharge 06/18/2012		HOS - Patient demonstrates appropriate expression of grief/loss.	N			
By Discharge 06/18/2012		Verbalizes that he/she is ready to die.	N			
By Discharge 06/18/2012		Patient verbalizes that he/she has no unresolved issues.	N			

Problem: EXPECTED OUTCOMES

Identified: 06/07/2012 Achieved:

<u>Target</u>	<u>Achieved</u>	<u>Outcomes</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>
06/18/2012		Verbalizes agreement with discharge plans or continued services.	N			

Grouped Clinician Diagnosis: Spiritual issues: altered access to faith/spiritual community, alteration in spiritual practices, altered belief system, altered life's meaning, need for closure, spiritual distress __

Interventions

Intervention Category: INTERTEAM/COMMUNITY - Spiritual/Chaplain

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
06/18/2012	Assess patient/family spiritual resources.	N	N				N
06/18/2012	Initiate contact with specified congregation/synagogue.	N	N				N
06/18/2012	Provide arrangement for requested sacraments.	N	N				N

Created: 6/18/2012 5:42:00PM

Printed: 8/26/2013 11:10:06AM

Completed: 6/21/2012 8:35:00PM

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Hospice Pre Post Patient Activity (Visit 06/16/2012)



1593112194

Customer: Farr, William G

Customer ID: 03570052

Admit ID: 00038224

Intervention Category: PSYCHOSOCIAL - Spiritual/Chaplain

Identified: 06/07/2012 Achieved:

<u>Achieved</u>	<u>Interventions</u>	<u>Performed</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>	<u>Move to Next Visit</u>
06/18/2012	Support verbalization/discussion of spiritual issues, grief/loss, closure, other ____.	N	N				N
06/18/2012	Provide belief system inquiry related to: life's meaning, adequacy of belief system, why me, isolation from communities sharing belief system; other ____.	N	N				N
06/18/2012	Initiate discussion as facilitated by: life review, validation of belief system, providing acceptance.	N	N				N

Problems

Problem: EXPECTED OUTCOMES - Spiritual/Chaplain

Identified: 06/07/2012 Achieved:

<u>Target</u>	<u>Achieved</u>	<u>Outcomes</u>	<u>Var</u>	<u>Var Type</u>	<u>Rsn Code</u>	<u>Act Cod</u>
By Discharge	06/18/2012	HOS - Patient verbalizes spiritual support is adequate.	N			
By Discharge	06/18/2012	HOS - Caregiver/family verbalize spiritual support is adequate.	N			
By Discharge	06/18/2012	HOS - Caregiver/family demonstrates appropriate expression of grief/loss.	N			
By Discharge	06/18/2012	Verbalizes how and when to contact Hospice staff	N			

Created: 6/18/2012 5:42:00PM

Printed: 8/26/2013 11:10:06AM

Completed: 6/21/2012 8:35:00PM

Author: Shelton, Sarah RN

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Union

Allergies NKDA**Farr, William****Nickname** Hot Shot**MRN** 102406**Start Of Care** 06/16/2012**Date Of Death:** 06/19/2012**Status** Deceased More**General Patient Details****Referral Date**
06/16/2012**Referral Source**
Edwards, Cheryl Lynn:
HCSC**Referral Obtained By**
Penny Adamo**Referral Office**
Union**General Patient Details****First Name**
William**Last Name**
Farr**Nickname**
Hot Shot**Date of Birth**
[REDACTED]**SSN**
[REDACTED]**Marital Status**
Married**Languages Spoken**
English**Spouse Name**
Delores**Race**
Caucasian**Gender**
Male**Physical Address****Address 1**
1032 Jonesville Lockhart
Hwy**City**
Union**State**
SC**County**
Union, SC**Zipcode**
29379-7711**Mailing Address****Mailing Address 1**
1032 Jonesville Lockhart
Hwy**Mailing City**
Union**Mailing State**
SC**Mailing Zipcode**
29379-7711**Patient Care Directives****Code Status**
DNR**Disaster Acuity**
NA**Diagnosis/Insurance Information****Diagnosis**
Primary: 162.9 -
Malignant neoplasm of
bronchus and lung,
unspecified **Secondary:**
496 - Chronic airway
obstruction, not
elsewhere classified
Tertiary: 786.09 Other
respiratory abnormalities
Diagnoses: Cancer
Other Comorbid: hx of
colon cancer, htn, mi,
depression**Level Of Care**
CONT**Primary Policy**
Medicare [REDACTED]**Secondary Policy****Location Information****Location**
Home

Referral Source DetailsNameEdwards, Cheryl Lynn:
HCSCWork Phone

864-398-2510

Referral Type

Employee/Volunteer

Attending PhysicianNameMehta, Sharmila:
Palmetto Hematology
OncologyProvider No

30618

Upin No

AA2655

Npi No

1447371281

Address380 Serpentine Drive
Suite 200 Spartanburg,
SC 29303Map(Google Map)
(MapQuest)Phone

864-560-7050

Fax

864-560-0801

Medical DirectorName

Wentz, Robert

Provider No

4895

Upin No

B92574

Npi No

1346261690

Address429 East Main Street
Union, SC 29379Map(Google Map)
(MapQuest)Phone

864-427-8826

DME Provider InformationName

AllCare Medical

Phone

888-299-0004

Fax

866-816-2784

Staff Assignments (Admin Team 3)

					Copy	CSV
Discipline	Name	Primary?	Visits	PRN Visits	Frequency Notes	
MD Director	Wentz, Robert	Yes				
Physician	Mehta, Sharmila: Palmetto Hematology Oncology	Yes				
Volunteer Coordinator	Hall, Kelly	No				
Showing 1 to 3 of 3 entries					← Previous	1 Next →

Consolo Indicator for William F. 102406 at Office Union

Patient Details for Farr, William 102406

Date Of Birth	07/06/1942	Status	Deceased

Indicator Dated 06/16/2012 for William Farr, Medical Record No 102406

Effective Date
06/16/2012

Status
TERM

Miscellaneous

Other Comorbid

hx of colon cancer, htn, mi, depression

Diagnoses

Cancer - Terminal Diagnosis

Symptoms

- A. Disease with distant metastases at presentation (SELECTED)
- B. Progression from an earlier stage of disease to metastatic disease with either a continued decline in spite of therapy OR patient declines further disease directed therapy (SELECTED)

Narrative

NYHA Class IV, PPS 30%, KPS 30%. 69yom with es lung cancer with hx of lung and colon cancer, colostomy from colon cancer, r upper and middle lung lobectomy, acute on chronic COPD, advanced lung cancer.

ICD9s

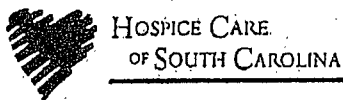
Primary ICD9 - 162.9 Malignant neoplasm of bronchus and lung, unspecified on 06/16/2012

Secondary ICD9 - 496 Chronic airway obstruction, not elsewhere classified on 06/16/2012

Tertiary ICD9 - 786.09 Other respiratory abnormalities on 06/16/2012

Signatures

1. RN Edwards, Lynn (User) signed on 06/16/2012. Recorded by lynn.edwards on 06/16/2012.



NAME: William Jarr ID# 102406 DATE: 6/14/12

CANCER NARRATIVE SUMMARY OF DISEASE PROGRESSION

Documentation should be comprehensive, specific, and measurable.

Summary and progression of illness (es) to include progressive disease and comorbid symptoms: confusion, mental behaviors, fatigue, dyspnea, nausea/vomiting, signs and symptoms of dehydration, difficulty swallowing, impaired skin integrity level of care changes, oral intake (meal % and consistency), change in functional (ADL) status.

Pt is a 69 yom c a history of complex ES lung disease. COPD-worsening. Severe dyspnea. Positive for lung Ct & prior lung resection. Hx of colon CA c colon resection & colostomy. Upper & R middle lobe ectomy. Cachectic & dyspneic even at rest.

CO-MORBIDITIES AND SYMPTOMS/ CONDITIONS affecting terminal diagnosis: (Check all that apply)

- ☒ Pulmonary Disease ☒ Cardiac Disease ☐ Liver Disease ☐ Dementia ☐ Renal Failure
☒ Pain Uncontrolled/Difficult to manage ☒ Other symptoms uncontrolled/difficult to manage
☒ Other: ulcers plug

☒ Meets ☐ Does not meet. Why? (Include additional information) _____

C. Edwards
RN Signature

6/14/12
Date

Documentation from physicians and healthcare facilities to support diagnosis should be obtained and placed in the Medical Record if available.

- ☒ H&P ☒ Radiology reports ☒ Biopsy/Path reports ☐ Operative reports ☐ Consultations



HOSPICE CARE
OF SOUTH CAROLINA

WORKSHEET SUMMARY CANCER

The purpose of this worksheet is to guide initial and recertification assessments. It must be accompanied by narrative documentation. **These are guidelines only**, clinical judgment is required in each case. Construct a narrative from the information on this worksheet and information from the patient, physician and available history. This form must be completed prior to admission and re-certification.

NAME: William G Farr ID# 10244p DATE: 6/16/12

1. ☐ Diagnosis confirmed through pathology or radiology.
2. ☒ Patient is no longer receiving curative care
3. ☒ There is evidence of end-stage disease and/or metastasis

OTHER ASSESSMENT DATA:

Functional Assessment:	Current	1 Month Previous	3 Months Previous
1. Bathing	T	I	T
2. Dressing	T	I	I
3. Feeding	T	T	I
4. Transfers	T	T	I
5. Continence of urine and stool	T	T (colostomy)	I
6. Ambulation	T	I	I
Other: Weight/BMI	24.5 132lbs	unknown	unknown
MAC	24.5	unknown	unknown

I – independent Ax1 – assist of one person Ax2 – assist of two people T – Total

Consolo RN Clinical Chart by Bailey, Beth Dated 06/16/2012 (9826467)

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details**Effective Date**
06/16/2012**Discipline**
RN**Chart Owner**
Bailey, Beth (bbail)**Created By**
Bailey, Beth (bbail)**Vital Sign Measurement****Patient Measurements****Height**
55**Weight**
132**BMI**
30**Body Systems Activity Musculoskeletal Finding****Level of Overall****Function on Admission**
3-Maximum Assist**Complaints or No Report**

Patient Complaint (dyspnea and fatigue)

Activities In Daily Living**Feeding**
2-Moderate Assist**Feeding Notes**
help when too tired**Dressing**
4-Complete Assist**Bathing**
4-Complete Assist**Toileting**
3-Maximum Assist**Ambulation**
4-Complete Assist**Transfers**
3-Maximum Assist**Other Activities****Money Handling**
4-Complete Assist**Medications**
4-Complete Assist**Medication Administration**
3-Maximum Assist**Mobility**

Alteration In Endurance (very poor), Poor Coordination and Balance, Gait Disturbance (very weak), Bed Or Chair Bound

Patient Used Mobility Equipment and Devices

Bedside Commode, Adjustable Bed, Bed Rails

Summary

Dependence on Assistance Indicated (Care Plan filed): Max, ADL Support/Care Provided By: family and staff

Body Systems Cardiac Circulatory Finding**Cardiac / Circulatory**

Dyspnea (severe/disabling), Dyspnea Intensity: Severe, Cyanosis (finger tips), Pedal Pulses (present)

Body Systems Communication Finding

Oriented To Person, Oriented To Place, Oriented To Time, Glasses

Body Systems Elimination Finding**Bowel**

Colostomy (LLQ)

Reminders and Comments

Elimination Aids (Senna S 2 tabs / day), LBM Location / Size: colostomy / L, LBM Date: 06/13/2012

Body Systems Neurology Finding

Pupils Equal / Reactive, Grasps Equal, Fatigue (severe), Coordination (poor), Balance (poor)

Body Systems Nutrition Hydration Finding

Consolo RN Clinical Chart by Bailey, Beth Dated 06/16/2012 (9826467)

Diet

Diet: As Tolerated, Appetite: POOR, Appetite Notes: d/t SOB and fatigue, Liquid Intake/24 Hours (adequate at this time)

Comments And Intensities

Feeding Provided By Caregiver

Body Systems Respiratory Oxygenation Finding

S.O.B., D.O.E., Without Exertion, Skin Color (pale), Congestion (throughout)

Location Of Congestion

RUL (lobectomy), RML (lobectomy), RLL (congestion), LUL (congestion), LLL (congestion)

Cough

Cough (frequent), Productive (at times), Productive Cough Color: white to tan, Productive Cough Amount: small, Productive Cough Frequency: occ

Other

HOB - Up, Inhalers, Hx of MI

Body Systems Self Esteem Mental Status Finding

Oriented (A&O x3), Disoriented (at times with meds), Anxiety (with breathing attacks), Altered Consciousness: ALERT

Comments And Intensities**Usual Method Of Handling Problems**

Prayer and family

Body Systems Skin Integrity Circulation Finding

Color (pale), Skin Turgor (poor), Wound / Drain (Behind R ear), Skin Breakdown: none, Bruises (BUE)

Coordination Of Care

RN/CM (Pam Phipps), LPN/LVN (Sandi Ivey), SW (Sherry Burnett), Chaplain (Wayne Cooke), Hospice Aide (Jamie Bumgarner), Medical Director (Dr Robert Wentz), Patient, Family, Caregiver

Discussion

Medication Record Updated, POC Updated, Referrals Made

Physician And Medical Director Contact

Physician Contacted, Medical Director Contacted, Communication: Spiritual needs assessed and pt is of the Christian faith and has an open relationship with God. Welcomes visits from HCSC chaplain. Chaplain contacted and spiritual needs met at this time. Family requests prayer with patient. Cultural needs assessed, pt caucasian, local to area and there are no cultural needs noted or voiced per pt or CG, cultural assessment complete. Medication Record Updated, Referrals Made, Physician Contacted, Medical Director Contacted., Orders Received

Mini Nutritional Assessment

<u>Height</u>	<u>Weight</u>	<u>BMI</u>	<u>MAC</u>
55	132.0	30.68	24.5
<u>Weight loss during the last three months?</u>			
1			
<u>Neuropsychological problems?</u>			
2			
<u>Body Mass Index</u>			
2			
<u>Total Screening</u>			
5			

Nutritional Assessment

Lives independently (not in a nursing home or hospital)?

1

Pressure sores or skin ulcers?

1

How much fluid (water, juice, coffee, tea, milk...) is consumed per day?

0.5

Mid Arm Circumference in cm

0.5

Total Assessment

8.0

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Morse Fall Assessment

Ambulatory Aid

1 - Bedrest/Nurse Assist

IV/Heparin Lock

Yes

Gait/Transferring

1 - Normal/Bedrest/Immobile

Mental Status

1 - Oriented to Own Ability

Nursing Pain History

IV/SC Delivery

Venous Access (Porta cath L upper chest)

Nursing Summary

Terminal Prognosis (ES Lung Cancer)

Nursing Summary Notes

Visit Notes

Pt was transferred to our services from SRMC Hospice House. Pt has been admitted with a dx of non-small cell lung cancer. Pt is bed bound and is transferred with max of 2 to BSC when tolerated. Pt has dyspnea that is severe even at rest but per pt is tolerable and his pain a 4/10 which is tolerable for him. Pt wants pain meds given when pain gets around 6 or higher. Pt has multiple bruises noted to BUE from needle sticks during admission at hospital. Pt had a RUL and RML lobectomy in 2010 and has a history of colon cancer 15 yrs ago with a colostomy LLQ of the abd. Extensive education provided on medication administration per myself and Lynn Edwards, RN PCC. Brian Farr the son was able to verbalize understanding and we will continue to reinforce education with him and family as well. Skin is warm, dry, and intact with no pressure areas at this time. Pt does have a raw area behind the R ear. Cotton placed between oxygen tubing and skin. Education provided to family and pt on no smoking while oxygen is in use.

Pain Observation

Scale Type

Verbal

Pain Type

Acute

Frequency

Frequent

Verbal Details

Present Intensity

4 - Some pain

Best Intensity

3 - Slight pain

Worst Intensity

10 - Worst possible pain

Verbal Patient

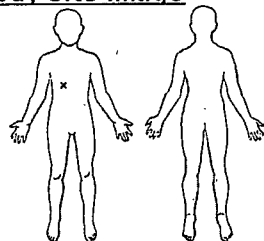
Acceptable Level of Pain
5 - Moderate pain

Location

Body Site

R chest - Internal

Body Site Image



Physician Order**Physician**

Mehta, Sharmila:
Palmetto Hematology
Oncology

Nurse

Bailey, Beth (bball)

Related to Terminal**Diagnosis?**

Yes

Orders

Admit to Hospice Care of SC via transfer SRMC Hospice House, with a terminal diagnosis of ES Lung Cancer with a life expectancy of 6 months or less to live if disease follows normal course.

Verbal Order Taken By

Bailey, Beth (bball)

Order Taken On

06/16/2012

Read Back Order to the**Physician?**

Yes

Related Medications**Related Assignees****Skin Integrity Assessment****Sensory Perception**

3 - Slightly Limited

Moisture

4 - Rarely Moist

Activity

1 - Bedfast

Mobility

2 - Very Limited

Nutrition

2 - Probably
Inadequate

Friction and Shear

2 - Potential Problem

Teaching And Learning Assessment**Taught By**

Bailey, Beth (bball)

Topics

Multiple Topics

Taught To

Immediate Family

Fields Taught

Patient, Family/Caregiver, Use & Proper Management of DME (Oxygen, bed, table, BSC), Medication (Extensive education), Disease Process, Signs and Symptoms of Impending Death, Pain Management, Skin Care, Symptom Management (Medication, distraction, etc), Positioning, Hydration, Education of Patients Rights/Responsibilities, Proper Medication Usage/Disposal, Assessment of Patient/PCG Ability of Administer Medications (Brian Farr), Nutrition

Vital Sign Measurement**Blood Pressure****Blood Pressure**

140/64

Blood Pressure Arm

Right

Blood Pressure Position

Lying

O₂

O₂ Sat (90%), O₂ Sat On: O₂, O₂ (Liters/min) (15L), Respiration: 30

Pulse**Radial Pulse**

111

Regular Radial Pulse?

Yes

Radial Pulse Quality

Strong

Temperature And Blood Sugar**Temperature**

96.8

Method

axillary

Skin Vitals**Skin Color**

Pallor

Skin Moisture

Normal

Skin Temperature

Warm

Performance Scales**Karnofsky**

30

Palliative

30

NYHA

Class IV

ECOG

4

Consolo RN Clinical Chart by Bailey, Beth Dated 06/16/2012 (9826467)

Patient Measurements

<u>Height</u>	<u>Weight</u>	<u>BMI</u>	<u>Mid-Arm Circumference</u>
55	132	30	<u>(cm)</u> 24.5

Mid-Arm Circumference

Arm
Right

Signatures

1. RN **Bailey, Beth** (User) signed on **06/16/2012**. Recorded by beth.bailey on 06/16/2012.
2. Physician **Mehta, Sharmila: Palmetto Hematology Oncology** (Physician) signed on **06/19/2012**. Recorded by sandi.ivey on 08/22/2012.

PATIENT NAME: FARR, WILLIAM G

MEDICAL RECORD #: 478684

DATE OF BIRTH: [REDACTED]

ACCOUNT NUMBER: 1216401412

DATE OF ADMISSION: 06/12/2012

ROOM:

HH09

HISTORY OF PRESENT ILLNESS

Mr. Farr is a 69-year-old man with a history of complex end-stage lung disease. He had baseline COPD and has had it for some time with progressive worsening. In addition, he had stage II non-small cell lung cancer in October 2010 and had right middle and lower lobectomies. He also had chemo radiation, but stopped after cycle 5 due to toxicity. He has had several admissions to the hospital for exacerbations of dyspnea and respiratory failure and CT scanning shows extensive bilateral infiltrates which have been difficult to assess precisely as far as infection versus lymphangitic carcinoma. That mystery still remains, despite multiple consultants, including infectious disease, pulmonology and oncology. Nevertheless, the bigger picture is of this man's overall performance status and symptom profile had been worsening. He is very cachectic and is quite dyspneic even at rest. He was discharged from the hospital on the 5th of June, admitted to hospice and returned to the hospital on the 10th of June after his family called 911. He was profoundly dyspneic, white count was elevated and chest x-ray did show bilateral infiltrates. He had a brief hospital stay, and after discussion of the primary care team with the patient, decision was made to transfer to the hospice home. He had couple of days of vancomycin and then was switched to Avelox by his primary care physician, Dr. Littlefield, who transferred him here on Avelox. His major symptom at this point is rather severe dyspnea at rest and marked worsening with any exertion. He is not really having pain at this point, and apart from anxiety, he is not really having any other symptoms. He transfers to the hospice home for symptom management, presumably as a conduit to return into the home setting with home hospice.

PAST MEDICAL HISTORY

Positive for lung cancer with previous lung resection; COPD; history of colon cancer with colon resection and colostomy; history of non-Q wave myocardial infarction; dyslipidemia by history.

SURGICAL HISTORY

Right upper lobe and right middle lobe lobectomy.

MEDICATIONS

Reviewed on his transfer forms.

ALLERGIES

None.

FAMILY HISTORY

Patient: FARR, WILLIAM G

MRN: 000478684

Encounter: 1216401412

Page 1 of 3

Noncontributory.

SOCIAL HISTORY

He was in a convenience store business. He has lived in Union his entire life. He is married and has 2 adult children. Spiritual: I do not have any information on that.

REVIEW OF SYSTEMS

As above.

PHYSICAL EXAMINATION

VITAL SIGNS: Temperature is 97.4, pulse is 101 at rest, respirations 29, BP is 114/82.

GENERAL: He is an alert man. He is apparently air hungry.

SKIN: Clear.

LYMPHATICS: Negative.

HEENT: PERRLA. Mucous membranes are moist.

CHEST: Reveals increased AP chest diameter.

LUNGS: Reveal bilateral inspiratory rhonchi and rales with a few end expiratory wheezes.

CARDIAC: Regular rhythm with tachycardia.

ABDOMEN: Soft, scaphoid. He is using accessory muscles of ventilation, nontender.

GENITALIA: Normal male.

EXTREMITIES: Symmetrical. Distal extremities are warm and well perfused. There is no peripheral edema.

NEUROLOGIC: Shows no focal neurologic signs.

ASSESSMENT

This is a 69-year-old man with acute-on-chronic respiratory failure, end-stage chronic obstructive pulmonary disease and very likely advanced lung cancer, though that is not entirely certain. He is admitted for symptom management and as a conduit to return home with home hospice.

RPS is 30%, New York Heart Association class IV.

PROGNOSIS FOR LIFE EXPECTANCY

Ill-defined at this point, but I would say would certainly be in the range of weeks to months at the outside.

PLANS

1. Symptom management in usual fashion with small doses of opioids and supplement with short-acting opioids if need be.
2. Standard management for end-stage COPD, bronchodilators, steroids, etc.
3. We will continue course of Avelox as started.
4. I had an extensive discussion with the patient's family initially and then with the family and the patient to clarify goals of care. Mr. Farr's daughter is not completely satisfied with the hospice plan of care, but it is allowing her father to choose and the rest of the family seems generally supportive, if rather faintly so, at this point. They still seem to be harboring hopes that he is going to get substantially better.
5. We will try to provide support to the family as they are willing to accept, particularly social and spiritual support, through this difficult time for them.

DICTATED BY: SNIPES, GARRETT E
DICTATED FOR (IF APPLICABLE):

D:06/12/2012 17:16:05
T:06/12/2012 22:13:37/un
1257589/1097770

Cc:SNIPES, GARRETT E, Attending Physician
H & P Page 3 of 3
FARR, WILLIAM G
478684

Note: Document is draft unless signed.<END FOOTER>

Consolo Certification for William F. at Office Union

Patient Details for Farr, William

Date Of Birth		Status	Deceased
Allergies	NKDA		
Start Of Care	06/16/2012	Gender	Male
Patient Address	1032 Jonesville Lockhart Hwy Union, SC 29379-7711		

Hospice Certification and Plan of Treatment

<u>Benefit Period</u>	<u>Benefit Period Start Date</u>	<u>Benefit Period End Date</u>	<u>Certification Start Date</u>
1	06/09/2012	09/06/2012	06/16/2012

<u>Physician</u>	<u>Medical Director or Certifying Physician</u>	<u>Signed Date</u>
Mehta, Sharmila: Palmetto Hematology Oncology	Wentz, Robert	06/25/2012

Orders for Clinical Disciplines and Treatments (Specify Amount/Duration)

Skilled Nurse visits to promote comfort and symptom management. LSW visits to provide psychosocial support to patient and family. CNA visits to assist with personal care, home making and to promote comfort per RN assignment. Chaplain visits to provide spiritual support to patient and family. Volunteer Services declined by patient/ family. Volunteer Services continue to be offered every week per Skilled Nurse/Staff.

Goals/Rehabilitation Potential/Discharge Plans

Assist with pain control and symptom management. Provide support to patient and family.

Physician Narrative

ES LUNG CA WITH 30% OF LUNG CAPACITY FREQUENT DYSPENIC EPISODE PRIOR HX OF LUNG CA AND COLON CA

<u>Patient HI Claim No</u>	<u>Disaster Acuity</u>
250680627A	Not yet defined

Provider Information

<u>Provider Name</u>	<u>Provider Number</u>	<u>Provider Address</u>
Union	421536	408 N. Duncan Bypass, Suite 6 Union, SC 293798663

Associated Nursing Clinical Chart

RN Clinical Chart by Bailey, Beth Dated 06/16/2012

Associated Plan of Care

Plan Of Care Dated: 06/19/2012

Consolo Certification for William F. at Office Union

Staff Assignments (Admin Team 3)

Discipline	Name	Primary?	Visits	PRN Visits	Frequency Notes
Volunteer Coordinator	Hall, Kelly	No			
Social Services	Burnett, Sherry	No			
Chaplain	Cooke, Wayne	No			
Hospice Aide	Davis, Kristin	No			
Hospice Aide	Wicker, Delphia	No			
Hospice Aide	Varner, Dawn	No			
Hospice Aide	Bumgarner, Jamie	No			
Hospice Aide	Ivey, Gwen	No			
Hospice Aide	Conard, Joel	Yes	5 visit(s) Weekly	15 PRN visit(s) every 90 day(s)	5 x weekly and prn
LPN/LVN	Ivey, Sandra	No			
RN	Bailey, Beth	No			
RN	Edwards, Lynn	No			
RN	Phipps, Pam	Yes	2 visit(s) Weekly	15 PRN visit(s) every 90 day(s)	2xweekly and prn
MD Director	Wentz, Robert	Yes			
Physician	Mehta, Sharmila: Palmetto Hematology Oncology	Yes			

Medications**Atropine [1 %] - Covered**

Order Date	06/18/2012	Ordering MD	Wentz, Robert
Admin By	Family	Directions	2 - 3 gtts every 3 hours As Needed Congestion (1 %)
Change	Added	Added Date	06/20/2012

Avelox [400 MG] PO Tablet - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (400 MG Tablet)
Change	Updated	Updated Date	06/16/2012

Consolo Certification for William F. at Office Union

Beclomethasone Dipropionate [42 mcg/dose] IN Aerosol, Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 puff(s) every 4 hours IN (42 mcg/dose Aerosol, Solution)
Change	Added	Added Date	06/16/2012
Additional Notes	Every 4 hours while AWAKE		

Citalopram Hydrobromide [20 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (20 MG Tablet)
Change	Added	Added Date	06/16/2012

Combivent [103 MCG/ACT; 18 MCG/ACT] IN - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 puff(s) every 4 hours IN (103;18 MCG/ACT)
Change	Added	Added Date	06/16/2012
Additional Notes	Every 4 hrs while awake		

Diazepam [5 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	0.5 - 0.5 tab every 12 hours PO (5 MG Tablet)
Change	Added	Added Date	06/16/2012

Lorazepam [0.5 mg] - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	0.5 - 1 mg every 2 hours As Needed Anxiety/Dyspnea (0.5 mg)
Change	Updated	Updated Date	06/16/2012
Additional Notes	*****0.25ml to 0.5ml*****		

LORazepam [0.5 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 2 tab every 4 hours PO As Needed Anxiety (0.5 MG Tablet)
Change	Updated	Updated Date	06/18/2012

Morphine Sulfate [4 mg/ml] IV Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 4 mg every 30 minutes IV As Needed (4 mg/ml Solution)
Change	Added	Added Date	06/16/2012

Mucinex [600 MG] PO Tablet Extended Release 12 Hour - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab every 12 hours PO (600 MG Tablet Extended Release 12 Hour)
Change	Added	Added Date	06/16/2012

Nicotine [21 MG/24HR] TD Patch 24 Hours - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 patch 1 times a day TD (21 MG/24HR Patch 24 Hours)
Change	Added	Added Date	06/16/2012

Oxycodone [5 mg] PO/SL Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 2 tab every 1 hours PO/SL As Needed Pain/SOB (5 mg Tablet)
Change	Added	Added Date	06/16/2012

OxyCONTIN [10 MG] PO Tablet Extended Release 12 Hour - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab every 12 hours PO (10 MG Tablet Extended Release 12 Hour)
Change	Added	Added Date	06/16/2012

PredniSONE [20 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 tab 1 times a day PO (20 MG Tablet)
Change	Added	Added Date	06/16/2012

Protonix [40 MG] PO Tablet Delayed Release - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (40 MG Tablet Delayed Release)
Change	Updated	Updated Date	06/16/2012
Additional Notes	DO NOT CRUSH		

Proventil HFA [108 (90 Base) MCG/ACT] IN Aerosol, Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 puff(s) every 2 hours IN As Needed SOB (108 (90 Base) MCG/ACT Aerosol, Solution)
Change	Updated	Updated Date	06/16/2012

Roxanol [20 MG/ML] PO Solution - Covered

Order Date	06/17/2012	Ordering MD	Wentz, Robert
Admin By	Family	Directions	1 ml every 1 hours PO As Needed Pain/SOB (20 MG/ML Solution)
Change	Updated	Updated Date	06/18/2012
Additional Notes	Every 1-2 hrs		

Senokot S [8.6 MG; 50 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 tab 1 times a day PO (8.6;50 MG Tablet)
Change	Added	Added Date	06/16/2012

Singulair [10 MG] PO Tablet - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (10 MG Tablet)
Change	Added	Added Date	06/16/2012

Theophylline [300 MG] PO Capsule Extended Release 24 Hour - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 cap(s) 1 times a day PO (300 MG Capsule Extended Release 24 Hour)
Change	Added	Added Date	06/16/2012

Consolo Certification for William F. at Office Union

Indicator Dated 06/16/2012 for William Farr, Medical Record No 102406

Effective Date

06/16/2012

Status

TERM

Miscellaneous**Other Comorbid**

hx of colon cancer, htn, mi, depression

ICD9s

Primary ICD9 - 162.9 Malignant neoplasm of bronchus and lung, unspecified on 06/16/2012

Secondary ICD9 - 496 Chronic airway obstruction, not elsewhere classified on 06/16/2012

Tertiary ICD9 - 786.09 Other respiratory abnormalities on 06/16/2012

Diagnoses**Cancer - Terminal Diagnosis****Symptoms****A. Disease with distant metastases at presentation (SELECTED)****B. Progression from an earlier stage of disease to metastatic disease with either a continued decline in spite of therapy OR patient declines further disease directed therapy (SELECTED)****Narrative**

NYHA Class IV, PPS 30%, KPS 30%. 69yom with es lung cancer with hx of lung and colon cancer, colostomy from colon cancer, r upper and middle lung lobectomy, acute on chronic COPD, advanced lung cancer.

Physician Orders between 06/02/2012 and 06/16/2012**Physician Order Details****Physician**Mehta, Sharmila:
Palmetto Hematology
Oncology**Nurse**

Edwards, Lynn (ledwa)

Related to Terminal**Diagnosis?**

Yes

Orders

Admit to Hospice Care of SC via transfer SRMC Hospice House, with a terminal diagnosis of ES Lung Cancer with a life expectancy of 6 months or less to live if disease follows normal course. Faxed order received from SRMC HH on 6-16-12.

Verbal Order Taken By

Edwards, Lynn (ledwa)

Order Taken On

06/16/2012

Read Back Order to the**Physician?**

Yes

Related Medications**Related Assignees****Physician Order Details****Physician**Mehta, Sharmila:
Palmetto Hematology
Oncology**Nurse**

Bailey, Beth (bbail)

Related to Terminal**Diagnosis?**

Yes

Orders

Admit to Hospice Care of SC via transfer SRMC Hospice House, with a terminal diagnosis of ES Lung Cancer with a life expectancy of 6 months or less to live if disease follows normal course.

Verbal Order Taken By

Bailey, Beth (bbail)

Order Taken On

06/16/2012

Read Back Order to the**Physician?**

Yes

Related Medications**Related Assignees**

Other Clinical Information	
Assessment Summary	Pt was transferred to our services from SRMC Hospice House. Pt has been admitted with a dx of non-small cell lung cancer. Pt is bed bound and is transferred with max of 2 to BSC when tolerated. Pt has dyspnea that is severe even at rest but per pt is tolerable and his pain a 4/10 which is tolerable for him. Pt wants pain meds given when pain gets around 6 or higher. Pt has multiple bruises noted to BUE from needle sticks during admission at hospital. Pt had a RUL and RML lobectomy in 2010 and has a history of colon cancer 15 yrs ago with a colostomy LLQ of the abd. Extensive education provided on medication administration per myself and Lynn Edwards, RN PCC. Brian Farr the son was able to verbalize understanding and we will continue to reinforce education with him and family as well. Skin is warm, dry, and intact with no pressure areas at this time. Pt does have a raw area behind the R ear. Cotton placed between oxygen tubing and skin. Education provided to family and pt on no smoking while oxygen is in use.
Diet	As Tolerated
Functional Limitations	Level of Overall Functioning on Admission: 3-Maximum Assist (), Feeding: 2-Moderate Assist, Feeding Notes: help when too tired, , Alteration In Endurance (very poor), Poor Coordination and Balance, Gait Disturbance (very weak), Bed Or Chair Bound,
Self-Esteem / Mental Status	Oriented (A&O x3), Disoriented (at times with meds), Anxiety (with breathing attacks), Altered Consciousness: ALERT
Imminence of Death	Terminal

Staff Information			
Physician Name	Mehta, Sharmila: Palmetto Hematology Oncology	Physician Address	380 Serpentine Drive Suite 200 Spartanburg, SC 29303
Physician Fax	864-560-0801		
Medical Director or Certifying Physician Name	Wentz, Robert	Medical Director or Certifying Physician Address	429 East Main Street Union, SC 29379

Plan Of Care dated 06/19/2012 for William Farr

Consolo Certification for William F. at Office Union

Name	Status	Category	Expected Outcome
Admission Plan of Care	COMPL	ADMISSION	

- **Assess Dietary needs, obtain orders and make referrals as necessary**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess for Immediate Global Needs**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess for Knowledge Deficit and provide needed education to Pt/Family/CG**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess for Pain/symptoms and intervene as necessary to bring to level of patient comfort**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess Immediate Psychosocial/Spiritual Needs - access Social Work support at time of admission**
 - 06/16/2012 - 06/19/2012
 - cooke/burnett
- **Assign Chaplain services as necessary for Spiritual needs identified on initial assessment**
 - 06/16/2012 - 06/19/2012
 - Wayne Cooke
- **Assign Hospice Aide service to provide for Personal Care needs**
 - 06/16/2012 - 06/19/2012
 - Jamie Bumgarner
- **Assign RN Case Manager to assess Scope of Service and oversee ongoing patient care needs**
 - 06/16/2012 - 06/19/2012
 - Pam Phipps, RN
- **Assign Social Work to assess for ongoing psychosocial/bereavement/volunteer needs**
 - 06/16/2012 - 06/19/2012
 - Sherry Burnett
- **Collaborate with Attending Physician for Admission orders and obtain Authorization**
 - 06/16/2012 - 06/19/2012
 - Mehta, Sharmila faxed authorization from SRMC Hospice House
- **Collaborate with Hospice Medical Director as necessary for support, Admission orders and obtain Authorization**
 - 06/16/2012 - 06/19/2012
 - R Wentz
- **Collaborate with Interdisciplinary Hospice Team for Team Agreement**
 - 06/16/2012 - 06/19/2012
 - PRN and at IDG
- **Collaborate with Referral Source/Facility/Institution**
 - 06/16/2012 - 06/19/2012
 - faxed records received from SRMCHH
- **Obtain DME/Supplies as needed for patient support**
 - 06/16/2012 - 06/19/2012
 - Allcare
- **Obtain Medication and Treatment Orders - institute immediately**
 - 06/16/2012 - 06/19/2012
 - covered via Hospiscript

Consolo Certification for William F. at Office Union

Name	Status	Category	Expected Outcome
Alteration in Pulmonary Function	COMPL	NURSE	

- **Adjust temperature and humidity as appropriate**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided
- **Assess for anxiety. Contact MD for possible benzodiazepines as appropriate**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess patient's respiratory status at each visit and prn**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Discuss use of opioids to relieve dyspnea. Obtain MD order and administer as prescribed**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **Evaluate possible cause of dyspnea (COPD exacerbation, thick secretions, anxiety, infection, etc)**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **If currently on opioids, evaluate effectiveness. Notify MD for changes and titrate as ordered**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **O2 as appropriate. Teach PCG appropriate use and when oxygen may be ineffective as disease progresses**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **Provide a draft (use of fans, open window, etc)**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN
- **Reposition for maximum comfort, encourage relaxation techniques**
 - 06/16/2012 - 06/19/2012
 - assessed by & education provided by Lynn Edwards, RN
- **Teach energy conservation techniques to maintain comfort (raise HOB, rest periods during activity, positioning to facilitate air exchange)**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided
- **Teach patient and PCG to call hospice for change in status**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **Teach patient and PCG to elevate HOB as needed to achieve maximum comfort**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided Lynn Edwards, RN

Consolo Certification for William F. at Office Union

Name	Status	Category	Expected Outcome
Coordination of Care Needs	COMPL	SOCIALWORKER	reviewed 6-19-12 : Collaboration and continuity of care will be maintained as appropriate to the patient/family psychosocial needs.

- **Assess for family/caregiver emotional concerns and psychosocial needs.**
 - 06/17/2012 - 06/19/2012
 -
- **Assess for patient emotional concerns and psychosocial needs.**
 - 06/17/2012 - 06/19/2012
 -
- **Continue communication and collaboration with disciplines providing care to the patient and addressing needs of patient/family**
 - 06/17/2012 - 06/19/2012
 -

Name	Status	Category	Expected Outcome
Coordination of Care Needs	COMPL	CHAPLAIN	Reviewed on 06/19/2012 Collaboration and continuity of care will be maintained as appropriate to the patient/family spiritual needs.

- **Assess for family/caregiver emotional concerns and spiritual needs.**
 - 06/17/2012 - 06/19/2012
 -
- **Assess for patient emotional concerns and spiritual needs.**
 - 06/17/2012 - 06/19/2012
 -
- **Continue communication and collaboration with disciplines providing care to the patient and addressing needs of patient/family**
 - 06/17/2012 - 06/19/2012
 -

Consolo Certification for William F. at Office Union

Name	Status	Category	Expected Outcome
Difficulty with Grief Process	COMPL	SOCIALWORKER	Reviewed 6-19-12: Patient and Family will be able to demonstrate uncomplicated grief process.

- **Alert bereavement staff to special needs of patient/ family**
 - 06/18/2012 - 06/19/2012
 -
- **Assess family dynamics and how they relate to grief process**
 - 06/18/2012 - 06/19/2012
 -
- **Assess family for anticipatory grief abilities; provide education on anticipatory grief**
 - 06/18/2012 - 06/19/2012
 -
- **Assess for suicide potential/ ideation**
 - 06/18/2012 - 06/19/2012
 -
- **Encourage and assist patient in life review and preparatory grief**
 - 06/18/2012 - 06/19/2012
 -
- **Explore past losses and coping style**
 - 06/18/2012 - 06/19/2012
 -
- **Other Interventions:**
 - 06/18/2012 - 06/18/2012
 - Gone from my sight book given to family

Consolo Certification for William F. at Office Union

Name	Status	Category	Expected Outcome
Dying Process	COMPL	NURSE	

- **Assess environment to facilitate peace and dignity**
 - 06/16/2012 - 06/19/2012
 - assessed and appropriate
- **Assess family coping needs**
 - 06/16/2012 - 06/19/2012
 - assessed and needs identified...education provided and on going
- **Assess patient's status(physical, psychosocial, emotional, and spiritual needs)**
 - 06/16/2012 - 06/19/2012
 - assessed
- **Assist with completion of funeral arrangements when appropriate**
 - 06/17/2012 - 06/19/2012
 - initiate discussion when appropriate
- **Communicate signs of impending death and dying. Communicate when changes occur during transition**
 - 06/17/2012 - 06/19/2012
 - Education provided and reinforced
- **Inform physician of patient status as warranted**
 - 06/17/2012 - 06/19/2012
 - MD contacted PCP is out of town
- **Initiate Crisis Care if appropriate**
 - 06/17/2012 - 06/19/2012
 - CC started @ 5:30am
- **Instruct family in patient comfort measures**
 - 06/17/2012 - 06/19/2012
 - Education provided and reinforced
- **Notify appropriate team members**
 - 06/17/2012 - 06/19/2012
 - done
- **Provide emotional support**
 - 06/17/2012 - 06/19/2012
 - emotional and spiritual support provided
- **Provide family with additional support and resources as needed**
 - 06/16/2012 - 06/19/2012
 - Education provided
- **Reinforce education from material(Patient and Family Guide, Gone from My Sight, etc.)**
 - 06/16/2012 - 06/19/2012
 - Sherry Burnett to take Gone From My Sight at initial visit
- **Teach family what to expect at time of death. Assess family roles and willingness to participate in care**
 - 06/16/2012 - 06/19/2012
 - education provided by Lynn Edwards, RN and Beth Bailey, RN

Consolo Certification for William F. at Office Union

Name	Status	Category	Expected Outcome
Elimination	COMPL	NURSE	

- **Assess current bowel and bladder pattern**
 - 06/16/2012 - 06/19/2012
 - assessed pt has colostomy
- **Assess for effective bowel regimen with stool softener and laxative of choice. Contact MD for orders as needed**
 - 06/16/2012 - 06/19/2012
 - stool softener in place
- **Provide Privacy**
 - 06/16/2012 - 06/19/2012
 -

Name	Status	Category	Expected Outcome
Nutrition/Hydration	COMPL	NURSE	

- **Assess BMI, MAC as appropriate for recertification. Evaluate trends**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey
- **Assess for increased confusion, and/or change in mental status**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey
- **Educate PCG in the effects of disease process on metabolism and appetite**
 - 06/16/2012 - 06/19/2012
 - assessed by and education provided by beth bailey
- **Instruct PCG in oral hygiene**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey

Name	Status	Category	Expected Outcome
Patient Activity Mobility and Safety	COMPL	NURSE	

- **Assess ADL needs encouraging optimal mobility and assist as needed**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey activity adlib
- **Instruct PCG in physical care of the immobilized patient including transfer, ambulation, smoking, safety lighting, etc**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey education provided including no smoking with O2 in use
- **PCG will be instructed in home safety, O2 usage, emergency planning, and safety**
 - 06/16/2012 - 06/19/2012
 - education provided by Lynn Edwards, RN and Allcare Rep
- **Place communication device(s), remotes, phone, snacks, needed items within arms reach**
 - 06/16/2012 - 06/19/2012
 - within reach on overbed table

Consolo Certification for William F. at Office Union

Name	Status	Category	Expected Outcome
Physical Comfort Alteration	COMPL	NURSE	

- **Assess for effects of unrelieved pain**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey pt able to vocalize pain level
- **Assess pain(level, duration, quality, contributory/alleviating factors, and effects) at each visit and prn**
 - 06/16/2012 - 06/19/2012
 - pt states pain <5 is tolerable
- **Educate caregivers and facility staff on principles of pain management**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Educate caregivers and facility staff to notify hospice nurse of changes in patient's pain management**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Instruct caregivers and facility staff in comfort measures - i.e., massage, bathing, positioning, soft music**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Utilize a numeric pain scale (0-10) consistently. If unable to communicate, utilize the FLACC scale**
 - 06/16/2012 - 06/19/2012
 - pt A&O x 3 and able to communicate level of pain

Name	Status	Category	Expected Outcome
Skin Integrity	COMPL	NURSE	

- **Assess skin integrity and effectiveness of skin care each visit**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey, rn
- **Evaluate effectiveness of interventions and discuss at IDG. Re-evaluate goals of care as needed**
 - 06/16/2012 - 06/19/2012
 - prn
- **Instruct patient/caregiver in turning and repositioning every two (2) hours**
 - 06/16/2012 - 06/19/2012
 - pt/pcg educated

Name	Status	Category	Expected Outcome
Spiritual Issues related to Acceptance of Death, and Utilization of Spiritual Resources.	COMPL	CHAPLAIN	Reviewed on 06/19/2012 Patient and family will have their Spiritual needs met.

- **Pray with patient**
 - 06/19/2012 - 06/19/2012
 -

Consolo Certification for William F. at Office Union

Name	Status	Category	Expected Outcome
Terminal Illness	COMPL	ADMISSION	

- **24-hour availability**
 - 06/16/2012 - 06/19/2012
 - assessed and education provided
- **Admit to hospice on Routine level of care**
 - 06/16/2012 - 06/19/2012
 - transferred from SRMC HH
- **Arrange for equipment as needed/accepted. Specify _____**
 - 06/16/2012 - 06/19/2012
 - See DME list in CTI
- **Arrange for Hospice Aide as needed/accepted**
 - 06/16/2012 - 06/19/2012
 - Jamie Bumgarner
- **Assess patient/family/PCG ability to administer medications**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Assess patient/family/PCG ability to deliver care**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Assess patient/family/PCG understanding of the disease process and care requirements**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Case Manager to manage/coordinate care**
 - 06/16/2012 - 06/19/2012
 - pam phipps
- **Generic drug equivalents many be used**
 - 06/16/2012 - 06/19/2012
 -
- **Instruct patient/family/PCG regarding medication and treatment regimen**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Involve patient/family/PCG in developing plan of care**
 - 06/16/2012 - 06/19/2012
 - IDG invitation provided and encouraged
- **No labs without hospice authorization**
 - 06/16/2012 - 06/19/2012
 - education provided
- **Notify hospice of any changes in condition**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Notify Primary MD of patient's admission to hospice. Specify _____**
 - 06/16/2012 - 06/19/2012
 - Sharmila Metha

Consolo Certification for William F. at Office Union

Nurse's Signature and Date of Verbal SOC Where Applicable _____

Date Signed POT Received _____

I (certify / recertify) that this patient is under my care, to the best of my medical knowledge given the data available, has a life expectancy of six (6) months or less if the disease runs its normal course. I authorize hospice care as outlined above. Care is to be provided on the basis of the Plan of Care contained in the records.

Attending Physician gives permission to the Medical Director to oversee the Plan of Care and make changes in care and medications as needed and reviewed by the Interdisciplinary Team.

Brief narrative statement: (Review the patient's clinical circumstances and synthesize the medical information to provide clinical justification for admission and continuation to hospice services)

ES LUNG CA WITH 30% OF LUNG CAPACITY FREQUENT DYSPNEIC EPISODE PRIOR HX OF LUNG CA AND COLON CA

Attestation: I confirm that this narrative is based on my review of the patient's medical record and/or examination of the patient. Anyone who misrepresents, falsifies or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal Laws.

Attending Physician's Name, Address, and Fax:

Mehta, Sharmila: Palmetto Hematology Oncology
380 Serpentine Drive
Suite 200
Spartanburg, SC 29303 864-560-0801

Attending Physician Signature:

Physician Mehta, Sharmila: Palmetto Hematology Oncology (Physician) signed on 06/19/2012. Recorded by lynn.edwards on 06/25/2012.

Medical Director or Certifying Physician's Name, Address, and Fax:

Wentz, Robert
429 East Main Street
Union, SC 29379

Medical Director or Certifying Physician's Signature:

Medical Director Wentz, Robert (Medical Director) signed on 06/19/2012. Recorded by lynn.edwards on 06/25/2012.

Signatures

1. RN Edwards, Lynn (User) signed on 06/25/2012. Recorded by lynn.edwards on 06/25/2012.
2. Medical Director Wentz, Robert (Medical Director) signed on 06/19/2012. Recorded by lynn.edwards on 06/25/2012.
3. Physician Mehta, Sharmila: Palmetto Hematology Oncology (Physician) signed on 06/19/2012. Recorded by lynn.edwards on 06/25/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

Current IDG Charts for William F. 102406**General Patient Details**

Admission Date 06/16/2012	Discharge Date 06/19/2012	Medical Record Number 102406	Level Of Care CONT
Disaster Acuity NA	Disaster Priority Tree	Physician Mehta, Sharmila: Palmetto Hematology Oncology	Code Status DNR
Imminence of Death No ()	Length of Service 4	Benefit Period 1	Recertification Date 09/07/2012
Allergies NKDA			

IDG Assignments**IDG Assignments**

Discipline	Name	Primary?	Visits	PRN Visits	Frequency Notes
Volunteer Coordinator	Hall, Kelly	No			
Social Services	Burnett, Sherry	No			
Chaplain	Cooke, Wayne	No			
Hospice Aide	Davis, Kristin	No			
Hospice Aide	Wicker, Delphia	No			
Hospice Aide	Varner, Dawn	No			
Hospice Aide	Bumgarner, Jamie	No			
Hospice Aide	Ivey, Gwen	No			
Hospice Aide	Conard, Joel	Yes	5 visit(s) Weekly	15 PRN visit(s) every 90 day(s)	5 x weekly and prn
LPN/LVN	Ivey, Sandra	No			
RN	Bailey, Beth	No			
RN	Edwards, Lynn	No			
RN	Phipps, Pam	Yes	2 visit(s) Weekly	15 PRN visit(s) every 90 day(s)	2xweekly and prn
MD Director	Wentz, Robert	Yes			
Physician	Mehta, Sharmila: Palmetto Hematology Oncology	Yes			

Indicators

Indicator Dated 06/16/2012 for William Farr, Medical Record No 102406

Effective Date
06/16/2012

Status
TERM

Miscellaneous**Other Comorbid**

hx of colon cancer, htn, mi, depression

Diagnoses**Cancer - Terminal Diagnosis****Symptoms**

A. Disease with distant metastases at presentation (SELECTED)

B. Progression from an earlier stage of disease to metastatic disease with either a continued decline in spite of therapy OR patient declines further disease directed therapy (SELECTED)

Narrative

NYHA Class IV, PPS 30%, KPS 30%. 69yom with es lung cancer with hx of lung and colon cancer, colostomy from colon cancer, r upper and middle lung lobectomy, acute on chronic COPD, advanced lung cancer.

ICD9s

Primary ICD9 - 162.9 Malignant neoplasm of bronchus and lung, unspecified on 06/16/2012

Secondary ICD9 - 496 Chronic airway obstruction, not elsewhere classified on 06/16/2012

Tertiary ICD9 - 786.09 Other respiratory abnormalities on 06/16/2012

Signatures

1. RN Edwards, Lynn (User) signed on 06/16/2012. Recorded by lynn.edwards on 06/16/2012.

Recent Visit Notes**Visit Note**

Effective Date
06/16/2012

Discipline
RN

Chart Owner
Bailey, Beth (bbail)

Created By
Bailey, Beth (bbail)

Time Of Event
2045

Visit Note Visit Type
Home *

Note

Visit made to assist and educate CG with administering Morphine push for first time d/t anxiety. Curtis was able to administer it using proper technique and timing, taking 1 minute to push morphine 2mg/1mL of morphine. He was able to flush properly and lock clamp back. Family was more at ease after this. Supplies taken for bed bath. Pt tolerated well and had relief of severe dyspnea after 5 minutes of dosing.

Once again family, pt, and CG were educated to call NURSE ON CALL with any questions or in an emergency and were able to verbalize understanding.

Visit Note

Effective Date
06/17/2012

Discipline
RN

Chart Owner
Bailey, Beth (bbail)

Created By
Bailey, Beth (bbail)

Time Of Event
0045

Visit Note Visit Type
Home *

Note

Visit made d/t call received from pts daughter c/o pt not being able to breathe, even after PRN medication administered. Upon arrival pt was sitting up on the side of the bed having a very difficult time breathing. CG did not give morphine push, I educated the CG to administer it and watched. Post 5 minutes morphine pt was then placed on the side of the bed leaning over on his over bed table to help with his breathing O2 sats at this time came up from 74% on 16L via NC to 78%. After about 15 minutes pt began to have another spell of very severe dyspnea. At this time CG was questioned and had not given PRN Ativan and was educated to give it SL d/t pt not being able to swallow while having severe dyspnea. Pt reported feeling better 8 minutes post Ativan. At this time pt wanted to lay back in the bed and began c/o pain in his L lower chest. CG at this time gave PRN Oxycontin IR 2 tabs. Pt reported feeling relief after 10 minutes massage and distraction was provided during this time. Pt O2 sat increased to 80%. I sat and comforted pt until family was comfortable with caring for pt and felt crisis was over.

Visit Note

<u>Effective Date</u> 06/17/2012	<u>Discipline</u> RN	<u>Chart Owner</u> Bailey, Beth (bbail)	<u>Created By</u> Bailey, Beth (bbail)
<u>Time Of Event</u> 0530	<u>Call Report</u> Yes	<u>Visit Note Visit Type</u> Home *	

Note

Crisis Care Initiated see hand written notes for further details

Visit Note

<u>Effective Date</u> 06/17/2012	<u>Discipline</u> RN	<u>Chart Owner</u> Bailey, Beth (bbail)	<u>Created By</u> Bailey, Beth (bbail)
<u>Time Of Event</u> 1200	<u>Visit Note Visit Type</u> Home *		

Note

Continuous Care visit see hand written notes

Visit Note

<u>Effective Date</u> 06/17/2012	<u>Discipline</u> LPN/LVN	<u>Chart Owner</u> Ivey, Sandra (sivey)	<u>Created By</u> Ivey, Sandra (sivey)
<u>Time Of Event</u> 1655	<u>Visit Note Visit Type</u> PRN *		

Note

Crisis Care Visit

Visit Note

<u>Effective Date</u> 06/17/2012	<u>Discipline</u> RN	<u>Chart Owner</u> Phipps, Pam (pphip)	<u>Created By</u> Phipps, Pam (pphip)
<u>Time Of Event</u> 0700	<u>Visit Note Visit Type</u> Home *		

Note

Crisis care visit- see written crisis care notes.

Visit Note

<u>Effective Date</u> 06/17/2012	<u>Discipline</u> Social Services	<u>Chart Owner</u> Burnett, Sherry (sburn)	<u>Created By</u> Burnett, Sherry (sburn)
<u>Time Of Event</u> 2000	<u>Visit Note Visit Type</u> Phone Call		

Note

Sw contacted family after being notified earlier today by Beth Bailey that patient had been started on crisis care. Daughter strong in her faith, still in denial. Sw offered emotional support and encouragement. Sw gave phone number in the event that family wanted a visit before monday from social worker.

Visit Note

<u>Effective Date</u> 06/18/2012	<u>Discipline</u> LPN/LVN	<u>Chart Owner</u> Ivey, Sandra (sivey)	<u>Created By</u> Ivey, Sandra (sivey)
<u>Time Of Event</u> 1055	<u>Visit Note Visit Type</u> LPN/LVN On Call Notes		

Note

Crisis Care Visit

Visit Note

<u>Effective Date</u> 12/19/2012	<u>Discipline</u> Social Services	<u>Chart Owner</u> Guthrie, Meredith Brooke (mguth)	<u>Created By</u> Guthrie, Meredith Brooke (mguth)

Time Of Event
2000

Visit Note Visit Type
Bereavement

Note

SW attempted contact with spouse Dolores Farr to conduct 6 month bereavement assessment. SW noted that phone number on file 864-426-5765 went straight to voice mail and had a recorded message of deceased client. SW left a message indicating name, role, purpose of call, contact information and request for a return call.

Supplementary Visit Note Information**Goals**

Accurate due dates for bereavement interventions.

Plans

Begin bereavement intervention tracking.

Interventions

1. Delegated staff member will enter effective date offset (2 days following the date of death) to begin the tracking.
2. Delegated staff person will enter the date of completion and/or contact date for any intervention as the particular intervention requires.

PCG Response

SW was unable to reach spouse. SW left a message. See Note above.

Symptom Notes

SW was unable to reach spouse.

Visit Note

Effective Date
12/27/2012

Discipline
Social Services

Chart Owner
Guthrie, Meredith
Brooke (mguth)

Created By
Guthrie, Meredith
Brooke (mguth)

Time Of Event
2000

Visit Note Visit Type
Bereavement

Note

SW attempted contact with spouse Dolores Farr to conduct 6 month bereavement assessment for the second time. SW noted that phone number on file 864-426-5765 went straight to voice mail and had a recorded message of deceased client. SW left a message indicating name, role, purpose of call, contact information and request for a return call.

Supplementary Visit Note Information**Goals**

Accurate due dates for bereavement interventions.

Plans

Begin bereavement intervention tracking.

Interventions

1. Delegated staff member will enter effective date offset (2 days following the date of death) to begin the tracking.
2. Delegated staff person will enter the date of completion and/or contact date for any intervention as the particular intervention requires.

PCG Response

SW was unable to reach spouse. SW left a second message. See Note above.

Symptom Notes

SW was unable to reach spouse.

Recent Nursing Summaries**Nursing Summary**

Effective Date
06/18/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Nursing Summary Notes**Visit Notes**

remained at home through the day r/t family dynamics and education of family and deescalation of family members/...continuous education provided mr/t EOL care, symptoms, management of symptoms

Family/Representative/CG Willingness and Capability to Care For Patient**Concerns**

Yes

Comments

many concerns including medication symptoms EOL

Nursing Summary**Effective Date**

06/18/2012

Discipline

RN

Chart Owner

Edwards, Lynn (ledwa)

Created By

Edwards, Lynn (ledwa)

Nursing Summary Notes**Visit Notes**

0645-0830 Crisis Care Coverage

Patient/Family/Representative/CG Goals

family dynamics....difficulty with teaching family EOL sx and mgt....

Nursing Summary**Effective Date**

06/18/2012

Discipline

RN

Chart Owner

Edwards, Lynn (ledwa)

Created By

Edwards, Lynn (ledwa)

Nursing Summary Notes**Visit Notes**

0416 call received from Susan M, LPN stating family was in crisis over patients declining condition and she needed help managing the situation.

0445 arrived at pts home spoke with family Susan M, Managed patient while this RN calmed family and spent time counseling family

remained at home with family until my CC shift began

Nursing Summary**Effective Date**

06/16/2012

Discipline

RN

Chart Owner

Bailey, Beth (bbail)

Created By

Bailey, Beth (bbail)

Terminal Prognosis (ES Lung Cancer)

Nursing Summary Notes**Visit Notes**

Pt was transferred to our services from SRMC Hospice House. Pt has been admitted with a dx of non-small cell lung cancer. Pt is bed bound and is transferred with max of 2 to BSC when tolerated. Pt has dyspnea that is severe even at rest but per pt is tolerable and his pain a 4/10 which is tolerable for him. Pt wants pain meds given when pain gets around 6 or higher. Pt has multiple bruises noted to BUE from needle sticks during admission at hospital. Pt had a RUL and RML lobectomy in 2010 and has a history of colon cancer 15 yrs ago with a colostomy LLQ of the abd. Extensive education provided on medication administration per myself and Lynn Edwards, RN PCC. Brian Farr the son was able to verbalize understanding and we will continue to reinforce education with him and family as well. Skin is warm, dry, and intact with no pressure areas at this time. Pt does have a raw area behind the R ear. Cotton placed between oxygen tubing and skin. Education provided to family and pt on no smoking while oxygen is in use.

Recent Pain Observations

Body Site	Effective Date	Resolved Date	User	Pain Type	Frequency	Scale Type	Score or Intensity	Verbal Acceptable Level	Comments
R chest	06/16/2012		Bailey, Beth	Acute	Frequent	Verbal	4	5	

Recently Updated Medications

Atropine [1 %] - Covered

Order Date	06/18/2012	Ordering MD	Wentz, Robert
Admin By	Family	Directions	2 - 3 gtts every 3 hours As Needed Congestion (1 %)
Change	Added	Added Date	06/20/2012

Avelox [400 MG] PO Tablet - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (400 MG Tablet)
Change	Updated	Updated Date	06/16/2012

Beclomethasone Dipropionate [42 mcg/dose] IN Aerosol, Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 puff(s) every 4 hours IN (42 mcg/dose Aerosol, Solution)
Change	Added	Added Date	06/16/2012
Additional Notes	Every 4 hours while AWAKE		

Citalopram Hydrobromide [20 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (20 MG Tablet)
Change	Added	Added Date	06/16/2012

Combivent [103 MCG/ACT; 18 MCG/ACT] IN - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 puff(s) every 4 hours IN (103;18 MCG/ACT)
Change	Added	Added Date	06/16/2012
Additional Notes	Every 4 hrs while awake		

Diazepam [5 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	0.5 - 0.5 tab every 12 hours PO (5 MG Tablet)
Change	Added	Added Date	06/16/2012

Lorazepam [0.5 mg] - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	0.5 - 1 mg every 2 hours As Needed Anxiety/Dyspnea (0.5 mg)
Change	Updated	Updated Date	06/16/2012
Additional Notes	*****0.25ml to 0.5ml*****		

LORazepam [0.5 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 2 tab every 4 hours PO As Needed Anxiety (0.5 MG Tablet)
Change	Updated	Updated Date	06/18/2012

Morphine Sulfate [4 mg/ml] IV Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 4 mg every 30 minutes IV As Needed (4 mg/ml Solution)
Change	Added	Added Date	06/16/2012

Mucinex [600 MG] PO Tablet Extended Release 12 Hour - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab every 12 hours PO (600 MG Tablet Extended Release 12 Hour)
Change	Added	Added Date	06/16/2012

Nicotine [21 MG/24HR] TD Patch 24 Hours - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 patch 1 times a day TD (21 MG/24HR Patch 24 Hours)
Change	Added	Added Date	06/16/2012

Oxycodone [5 mg] PO/SL Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 2 tab every 1 hours PO/SL As Needed Pain/SOB (5 mg Tablet)
Change	Added	Added Date	06/16/2012

OxyCONTIN [10 MG] PO Tablet Extended Release 12 Hour - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab every 12 hours PO (10 MG Tablet Extended Release 12 Hour)
Change	Added	Added Date	06/16/2012

PredniSONE [20 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 tab 1 times a day PO (20 MG Tablet)
Change	Added	Added Date	06/16/2012

Protonix [40 MG] PO Tablet Delayed Release - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (40 MG Tablet Delayed Release)
Change	Updated	Updated Date	06/16/2012
Additional Notes	DO NOT CRUSH		

Proventil HFA [108 (90 Base) MCG/ACT] IN Aerosol, Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 puff(s) every 2 hours IN As Needed SOB (108 (90 Base) MCG/ACT Aerosol, Solution)
Change	Updated	Updated Date	06/16/2012

Roxanol [20 MG/ML] PO Solution - Covered

Order Date	06/17/2012	Ordering MD	Wentz, Robert
Admin By	Family	Directions	1 ml every 1 hours PO As Needed Pain/SOB (20 MG/ML Solution)
Change	Updated	Updated Date	06/18/2012
Additional Notes	Every 1-2 hrs		

Senokot S [8.6 MG; 50 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 tab 1 times a day PO (8.6;50 MG Tablet)
Change	Added	Added Date	06/16/2012

Consolo IDG Comprehensive Assessment 06/20/2012 for William F. 102406 at Office Union

Singular [10 MG] PO Tablet - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (10 MG Tablet)
Change	Added	Added Date	06/16/2012

Theophylline [300 MG] PO Capsule Extended Release 24 Hour - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 cap(s) 1 times a day PO (300 MG Capsule Extended Release 24 Hour)
Change	Added	Added Date	06/16/2012

All Non-Recently Updated Active Medications**Recent Physician Orders****Physician Order**

<u>Effective Date</u> 06/18/2012	<u>Discipline</u> RN	<u>Chart Owner</u> Bailey, Beth (bbail)	<u>Created By</u> Bailey, Beth (bbail)
<u>Physician</u> Wentz, Robert	<u>Nurse</u> Bailey, Beth (bbail)	<u>Related to Terminal Diagnosis?</u> Yes	

Orders

Atropine 2 - 3 gtts every 3 hours SL As Needed Congestion (1 % Liquid)

<u>Verbal Order Taken By</u> Bailey, Beth (bbail)	<u>Order Taken On</u> 06/18/2012	<u>Read Back Order to the Physician?</u> Yes

Related Medications**Related Assignees****Physician Order**

<u>Effective Date</u> 06/18/2012	<u>Discipline</u> RN	<u>Chart Owner</u> Edwards, Lynn (ledwa)	<u>Created By</u> Edwards, Lynn (ledwa)
<u>Physician</u> Wentz, Robert	<u>Nurse</u> Edwards, Lynn (ledwa)	<u>Related to Terminal Diagnosis?</u> Yes	

Orders

LORazepam 1 - 2 tab every 4 hours PO/SL As Needed for Anxiety (0.5 MG Tablet) dispense #20 no refills.

<u>Verbal Order Taken By</u> Edwards, Lynn (ledwa)	<u>Order Taken On</u> 06/18/2012	<u>Read Back Order to the Physician?</u> Yes

Related Medications

LORazepam 1 - 2 tab every 4 hours PO As Needed Anxiety (0.5 MG Tablet)

Related Assignees

Physician Order

<u>Effective Date</u> 06/17/2012	<u>Discipline</u> RN	<u>Chart Owner</u> Bailey, Beth (bbail)	<u>Created By</u> Bailey, Beth (bbail)

<u>Physician</u> Wentz, Robert	<u>Nurse</u> Bailey, Beth (bbail)	<u>Related to Terminal Diagnosis?</u> Yes

Orders

Begin Continuous Care
Roxanol 1 ml every 2 to 3 hours PO As Needed Pain/SOB (20 MG/ML Solution)

<u>Verbal Order Taken By</u> Bailey, Beth (bbail)	<u>Order Taken On</u> 06/17/2012	<u>Read Back Order to the Physician?</u> Yes

Related Medications

Related Assignees

Physician Order

<u>Effective Date</u> 06/16/2012	<u>Discipline</u> RN	<u>Chart Owner</u> Edwards, Lynn (ledwa)	<u>Created By</u> Edwards, Lynn (ledwa)

<u>Physician</u> Mehta, Sharmila: Palmetto Hematology Oncology	<u>Nurse</u> Edwards, Lynn (ledwa)	<u>Related to Terminal Diagnosis?</u> Yes

Orders

Admit to Hospice Care of SC via transfer SRMC Hospice House, with a terminal diagnosis of ES Lung Cancer with a life expectancy of 6 months or less to live if disease follows normal course. Faxed order received from SRMC HH on 6-16-12.

<u>Verbal Order Taken By</u> Edwards, Lynn (ledwa)	<u>Order Taken On</u> 06/16/2012	<u>Read Back Order to the Physician?</u> Yes

Related Medications

Related Assignees

Physician Order

<u>Effective Date</u> 06/16/2012	<u>Discipline</u> RN	<u>Chart Owner</u> Bailey, Beth (bbail)	<u>Created By</u> Bailey, Beth (bbail)

<u>Physician</u> Mehta, Sharmila: Palmetto Hematology Oncology	<u>Nurse</u> Bailey, Beth (bbail)	<u>Related to Terminal Diagnosis?</u> Yes

Orders

Admit to Hospice Care of SC via transfer SRMC Hospice House, with a terminal diagnosis of ES Lung Cancer with a life expectancy of 6 months or less to live if disease follows normal course.

<u>Verbal Order Taken By</u> Bailey, Beth (bbail)	<u>Order Taken On</u> 06/16/2012	<u>Read Back Order to the Physician?</u> Yes

Related Medications

Related Assignees

Current Hospice Aide Assignment

Hospice Aide Assignment

Effective Date 06/16/2012	Assignment Frequency 5 visit(s) Weekly 15 PRN visit(s) every 90 day(s)	Hospice Aide Bumgarner, Jamie (jbumg)	Requesting User Edwards, Lynn (ledwa)

Hospice Aide Tasks

Activated Tasks

Activity

Ambulation [Yes], Assist with R.O.M./Exercise [Yes], Reposition/Turn Every 2 Hours [Yes], Up In Chair [Yes]

Additional Care

Homemaking Activities [Yes], TPR, BP [Yes]

Dietary

Assist with Meal [Yes], Diet [Yes] (ad lib), Encourage Fluids [Yes], Feed [Yes] (prn), Food Preparation [Yes]

Elimination

Bathroom with Assistance [Yes], Check Daily Bowel Movement [Yes]

Personal Care

Assist Bed Bath [Yes], Assist with Getting Dressed [Yes], Brush Hair [Yes], Complete Bed Bath [Yes] (prn), Denture Care [Yes] (prn), Draw Sheet [Yes], Linen Change [Yes], Nail Care [Yes], Oral Hygiene [Yes], Shave [Yes], Shower [Yes] (prn), Skin Care [Yes]

Bereavement Care Plan effective 06/21/2012

Bereavement Care Plan Dated: 06/21/2012			
Date Of Death	06/19/2012	Survivor Name	Farr, Dolores
Effective Date	06/21/2012	Relationship	Spouse
Update Date	03/25/2013 11:05 EDT	Address	1032 Jonesville Lockhart Hwy
Issues	Begin bereavement intervention tracking	City	Union SC 29379
Goals	Accurate due dates for bereavement interventions	Phone	m: 864-426-5765
Other Interventions	1. Delegated staff member will enter effective date offset (2 days following the date of death) to begin the tracking. 2. Delegated staff person will enter the date of completion and/or contact date for any intervention as the particular intervention requires.		

Bereavement Interventions

Consolo IDG Comprehensive Assessment 06/20/2012 for William F. 102406 at Office Union

Contact Date	Completion Date	Contact Type	Comments
06/20/2012		Phone Call	Condolence Call - Social Worker
06/20/2012		Phone Call	Condolence Call - Chaplain
06/21/2012		Flowers	Single White Rose to funeral home
06/24/2012		Card	Sympathy card to family
08/03/2012	12/19/2012	other	Bereavement Assessment - Bereavement Coordinator; Attempted. Message Left. SW will F/U with another call at a later time.
09/17/2012	10/02/2012	Letter	3 month letter - educational mailing
12/16/2012		other	6 month Bereavement follow up assessment -Bereavement Coordinator
03/16/2013	03/11/2013	Letter	9 month letter - educational mailing by BJH ***Return to sender son such number unable to forward***

Physician Information

Physician Name	Mehta, Sharmila: Palmetto Hematology Oncology	Physician Address	380 Serpentine Drive Suite 200 Spartanburg, SC 29303
Physician Fax	864-560-0801		

IDG Comprehensive Assessment Details

Consolo IDG Comprehensive Assessment 06/20/2012 for William F. 102406 at Office Union

Effective Date
06/20/2012

Bereavement
Assessment discussed
(if deceased)?
Yes

Recertification
discussed (if
recertification)?
N/A

IDG Meeting Notes
Goals Met

Volunteer Services
Offered (Other):
N/A

Comprehensive
Medication Review
N/A

Medication Review
Follow-Up

Patient/Caregiver is in
continued agreement
with POC
N/A

Primary Physician
notified of updated POC
No

Patient and/or family/caregivers have been determined to be safely administering medications/biologicals
N/A

Medication/Biologicals Administration Plan

Patient/Caregiver able and willing to provide care
N/A

Patient/Caregiver plan for providing care

Other

Patient/Caregiver POC change requests

Additional Comprehensive Assessment Comments

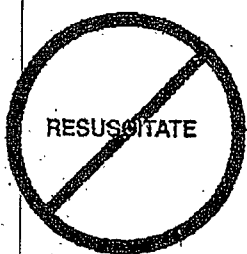
Pt passed during continuous care.

Issues For Next IDG Meeting

Signatures

1. Chaplain **Cooke, Wayne** (User) signed on **06/20/2012**. Recorded by wayne.cooke on 06/20/2012.
2. Social Services **Burnett, Sherry** (User) signed on **06/20/2012**. Recorded by sherry.burnett on 06/20/2012.
3. Hospice Aide **Davis, Kristin** (User) signed on **06/20/2012**. Recorded by kristin.davis on 06/20/2012.
4. RN **Edwards, Lynn** (User) signed on **06/20/2012**. Recorded by lynn.edwards on 06/20/2012.
5. RN **Phipps, Pam** (User) signed on **06/20/2012**. Recorded by pam.phipps on 06/20/2012.
6. Medical Director **Wentz, Robert** (Medical Director) signed on **06/20/2012**. Recorded by robert.wentz on 06/20/2012.
7. Hospice Aide **Varner, Dawn** (User) signed on **06/20/2012**. Recorded by dawn.varner on 06/20/2012.
8. Hospice Aide **Bumgarner, Jamie** (User) signed on **06/20/2012**. Recorded by jamie.bumgarner on 06/20/2012.
9. Hospice Aide **Ivey, Gwen** (User) signed on **06/20/2012**. Recorded by gwen.ivey on 06/20/2012.
10. Hospice Aide **Conard, Joel** (User) signed on **06/20/2012**. Recorded by joel.conard on 06/20/2012.
11. LPN/LVN **Ivey, Sandra** (User) signed on **06/20/2012**. Recorded by sandi.ivey on 06/20/2012.
12. RN **Bailey, Beth** (User) signed on **06/20/2012**. Recorded by beth.bailey on 06/20/2012.

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 D H E C PROMOTE PROTECT PROSPER	Emergency Medical Services Do Not Resuscitate Order
SOUTH CAROLINA EMERGENCY MEDICAL SERVICES	
 RESUSCITATE	
DO NOT RESUSCITATE ORDER	
NOTICE TO EMS PERSONNEL	
This notice is to inform all emergency medical personnel who may be called to render assistance to <u>William Farr</u> that he/she has a terminal condition which has been diagnosed by me and has (Name of Patient) specifically requested that no resuscitative efforts including artificial stimulation of the cardiopulmonary system by electrical, mechanical, or manual means be made in the event of cardiopulmonary arrest.	
REVOCATION PROCEDURE	
THIS FORM MAY BE REVOKED BY AN ORAL STATEMENT BY THE PATIENT TO EMS PERSONNEL, OR BY MULTILATING, OBLITERATING, OR DESTROYING THE DOCUMENT IN ANY MANNER:	
Date <u>6/12/12</u>	Patient's Signature (or Surrogate or Agent) <u>[Signature]</u>
Physician's Name (Please Print) <u>Omur Alexander</u>	Physician's Signature <u>[Signature]</u>
Physician's Address <u>101 S. Wood St</u>	Physician's Telephone Number <u>864-566-6000</u>

DHEC 3482 (12/2000) SOUTH CAROLINA DEPARTMENT OF HEALTH AND ENVIR

1216401412 000-678684 06/12/12
FARR, WILLIAM G M 69Y
ADM: SNIPES, GARRETT E
REP: SNIPES, GARRETT E



Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/16/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Physician Order

Physician
Mehta, Sharmila:
Palmetto Hematology
Oncology

Nurse
Edwards, Lynn (ledwa)

**Related to Terminal
Diagnosis?**
Yes

Orders

Admit to Hospice Care of SC via transfer SRMC Hospice House, with a terminal diagnosis of ES Lung Cancer with a life expectancy of 6 months or less to live if disease follows normal course. Faxed order received from SRMC HH on 6-16-12.

Verbal Order Taken By
Edwards, Lynn (ledwa)

Order Taken On
06/16/2012

**Read Back Order to the
Physician?**
Yes

Related Medications

Related Assignees

Signatures

1. RN Edwards, Lynn (User) signed on 06 16 2012. Recorded by lynn.edwards on 06/16/2012.
2. Physician Mehta, Sharmila Palmetto Hematology Oncology (Physician) signed on 06 16 2012. Recorded by lynn.edwards on 06/25/2012.

Patient Details for Farr, William 102406

Date Of Birth [REDACTED]	Status Deceased

General Clinical Chart Details

Effective Date
06/17/2012

Discipline
RN

Chart Owner
Bailey, Beth (bbail)

Created By
Bailey, Beth (bbail)

Physician Order

Physician
Wentz, Robert

Nurse
Bailey, Beth (bbail)

**Related to Terminal
Diagnosis?**
Yes

Orders

Begin Continuous Care
Roxanol 1 ml every 2 to 3 hours PO As Needed Pain/SOB (20 MG/ML Solution)

Verbal Order Taken By
Bailey, Beth (bbail)

Order Taken On
06/17/2012

**Read Back Order to the
Physician?**
Yes

Related Medications**Related Assignees****Signatures**

1. Medical Director **Went Robert** (Medical Director) signed on **06 1 2012**. Recorded by lynn.edwards on 08/23/2012.
2. RN **Bailey, Beth** (User) signed on **06 1 2012**. Recorded by beth.bailey on 06/17/2012.

Consolidated Clinical Chart for William Farr 102406 at Office Union

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/17/2012

Discipline
RN

Chart Owner
Bailey, Beth (beth.bailey)

Created By
Bailey, Beth (beth.bailey)

Physician Order

Physician
Wentz, Robert

Nurse
Bailey, Beth (beth.bailey)

Related to Terminal
Diagnosis?
Yes

Orders

Begin Continuous Care
Roxanol 1 ml every 2 to 3 hours PO As Needed Pain/SOB. (20 MG/ML Solution)

Verbal Order Taken By
Bailey, Beth (beth.bailey)

Order Taken On
06/17/2012

Read Back Order to the
Physician?
Yes

Related Medications

Related Assignees

Signatures

1. RN Bailey, Beth (User) signed on 06/17/2012. Recorded by beth.bailey on 06/17/2012.

Signature:

Robert Wentz

Date:

06/17/12

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
RN

Chart Owner
Bailey, Beth (bbail)

Created By
Bailey, Beth (bbail)

Physician Order

Physician
Wentz, Robert

Nurse
Bailey, Beth (bbail)

Related to Terminal
Diagnosis?
Yes

Orders

Atropine 2 - 3 gtts every 3 hours SL As Needed Congestion (1 % Liquid)

Verbal Order Taken By
Bailey, Beth (bbail)

Order Taken On
06/18/2012

Read Back Order to the
Physician?
Yes

Related Medications

Related Assignees

Signatures

1. RN **Bailey, Beth** (User) signed on **06/20/2012**. Recorded by beth.bailey on 06/20/2012.
2. Medical Director **Wentz, Robert** (Medical Director) signed on **06/20/2012**. Recorded by lynn.edwards on 06/25/2012.

Consolo Clinical Chart for William Farr 102406 at Office Union

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date 06/18/2012	Discipline RN	Chart Owner Bailey, Beth (beth.bailey)	Created By Bailey, Beth (beth.bailey)

Physician Order

Physician Wentz, Robert	Nurse Bailey, Beth (beth.bailey)	Related to Terminal Diagnosis? Yes

Orders
Atropine 2 - 3 gits every 3 hours SL As Needed Congestion (1 % Liquid)

Verbal Order Taken By Bailey, Beth (beth.bailey)	Order Taken On 06/18/2012	Read Back Order to the Physician? Yes

Related Medications

Signatures

1. RN Bailey, Beth (User) signed on 06/20/2012. Recorded by beth.bailey on 06/20/2012.

Signature:

[Handwritten Signature]

Date:

06/20/12

Consolo RN Clinical Chart by Edwards, Lynn Dated 06/18/2012 (9841801)

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details**Effective Date**
06/18/2012**Discipline**
RN**Chart Owner**
Edwards, Lynn (ledwa)**Created By**
Edwards, Lynn (ledwa)**Physician Order****Physician**
Wentz, Robert**Nurse**
Edwards, Lynn (ledwa)**Related to Terminal
Diagnosis?**
Yes**Orders**

LORazepam 1 - 2 tab every 4 hours PO/SL As Needed for Anxiety (0.5 MG Tablet) dispense #20 no refills.

Verbal Order Taken By
Edwards, Lynn (ledwa)**Order Taken On**
06/18/2012**Read Back Order to the
Physician?**
Yes**Related Medications**

LORazepam 1 - 2 tab every 4 hours PO As Needed Anxiety (0.5 MG Tablet)

Related Assignees**Signatures**

1. RN **Edwards, ynn**(User) signed on **06 1 2012**. Recorded by lynn.edwards on 06/18/2012.
2. Medical Director **Wentz, Robert**(Medical Director) signed on **06 1 2012**. Recorded by lynn.edwards on 06/18/2012.

Delivery

2-Net
Advanced DME Management

Patient:	Farr, William
Payer:	Hospice Care of SC (Union)
Placed By:	Bell Bailey
Placed Date:	06/18/2012 10:57 AM
Type:	Delivery
Oxygen Prescribed by:	

EQUIPMENT REQUESTED

PO:	
Facility:	
Items:	RESU PUMP Suction Pump (With Supplies)
Other Items/Instructions:	

Z-Net™
Advanced DME Management

Delivery

Patient:	Earl, William
Payer:	Hospice Care of SC (Union)
Placed By:	Beth Bailey
Placed Date:	06/18/2012 10:57 AM
Type:	Delivery
Oxygen Prescribed by:	

EQUIPMENT REQUESTED

PO#	
Facility:	
Items	RESURPUMP, Suction Pump (With Supplies)
Other Items/Instructions:	

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased
Allergies	NKDA		
Current Indicator	162.9 - Malignant neoplasm of bronchus and lung, unspecified		

Atropine [1 %] - Covered

Order Date	06/18/2012	Ordering MD	Wentz, Robert
Admin By	Family	Directions	2 - 3 gtts every 3 hours As Needed Congestion (1 %)
Change	Added	Added Date	06/20/2012

Avelox [400 MG] PO Tablet - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (400 MG Tablet)
Change	Updated	Updated Date	06/16/2012

Beclomethasone Dipropionate [42 mcg/dose] IN Aerosol, Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 puff(s) every 4 hours IN (42 mcg/dose Aerosol, Solution)
Change	Added	Added Date	06/16/2012
Additional Notes	Every 4 hours while AWAKE		

Citalopram Hydrobromide [20 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (20 MG Tablet)
Change	Added	Added Date	06/16/2012

Combivent [103 MCG/ACT; 18 MCG/ACT] IN - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 puff(s) every 4 hours IN (103;18 MCG/ACT)
Change	Added	Added Date	06/16/2012
Additional Notes	Every 4 hrs while awake		

Diazepam [5 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	0.5 - 0.5 tab every 12 hours PO (5 MG Tablet)
Change	Added	Added Date	06/16/2012

Lorazepam [0.5 mg] - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	0.5 - 1 mg every 2 hours As Needed Anxiety/Dyspnea (0.5 mg)
Change	Updated	Updated Date	06/16/2012
Additional Notes	*****0.25ml to 0.5ml*****		

LORazepam [0.5 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 2 tab every 4 hours PO As Needed Anxiety (0.5 MG Tablet)
Change	Updated	Updated Date	06/18/2012

Morphine Sulfate [4 mg/ml] IV Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 4 mg every 30 minutes IV As Needed (4 mg/ml Solution)
Change	Added	Added Date	06/16/2012

Mucinex [600 MG] PO Tablet Extended Release 12 Hour - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab every 12 hours PO (600 MG Tablet Extended Release 12 Hour)
Change	Added	Added Date	06/16/2012

Nicotine [21 MG/24HR] TD Patch 24 Hours - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 patch 1 times a day TD (21 MG/24HR Patch 24 Hours)
Change	Added	Added Date	06/16/2012

Oxycodone [5 mg] PO/SL Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 2 tab every 1 hours PO/SL As Needed Pain/SOB (5 mg Tablet)
Change	Added	Added Date	06/16/2012

OxyCONTIN [10 MG] PO Tablet Extended Release 12 Hour - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab every 12 hours PO (10 MG Tablet Extended Release 12 Hour)
Change	Added	Added Date	06/16/2012

PredniSONE [20 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 - 2 tab 1 times a day PO (20 MG Tablet)
Change	Added	Added Date	06/16/2012

Protonix [40 MG] PO Tablet Delayed Release - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (40 MG Tablet Delayed Release)
Change	Updated	Updated Date	06/16/2012
Additional Notes	DO NOT CRUSH		

Proventil HFA [108 (90 Base) MCG/ACT] IN Aerosol, Solution - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 puff(s) every 2 hours IN As Needed SOB (108 (90 Base) MCG/ACT Aerosol, Solution)
Change	Updated	Updated Date	06/16/2012

Roxanol [20 MG/ML] PO Solution - Covered

Order Date	06/17/2012	Ordering MD	Wentz, Robert
Admin By	Family	Directions	1 ml every 1 hours PO As Needed Pain/SOB (20 MG/ML Solution)
Change	Updated	Updated Date	06/18/2012
Additional Notes	Every 1-2 hrs		

Senokot S [8.6 MG; 50 MG] PO Tablet - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	2 tab 1 times a day PO (8.6;50 MG Tablet)
Change	Added	Added Date	06/16/2012

Singulair [10 MG] PO Tablet - Not Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 tab 1 times a day PO (10 MG Tablet)
Change	Added	Added Date	06/16/2012

Theophylline [300 MG] PO Capsule Extended Release 24 Hour - Covered

Order Date	06/16/2012	Ordering MD	Mehta, Sharmila: Palmetto Hematology Oncology
Admin By	Family	Directions	1 - 1 cap(s) 1 times a day PO (300 MG Capsule Extended Release 24 Hour)
Change	Added	Added Date	06/16/2012

I have reviewed the medications to identify any potential adverse effects and drug reactions including ineffective drug therapy, significant side effects, significant drug interactions, significant drug and food interactions, duplicate drug therapy, and non-compliance.

RPH signature

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

Plan Of Care dated 06/19/2012 for William Farr

Name	Status	Category	Expected Outcome
Admission Plan of Care	COMPL	ADMISSION	

- **Assess Dietary needs, obtain orders and make referrals as necessary**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess for Immediate Global Needs**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess for Knowledge Deficit and provide needed education to Pt/Family/CG**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess for Pain/symptoms and intervene as necessary to bring to level of patient comfort**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess Immediate Psychosocial/Spiritual Needs - access Social Work support at time of admission**
 - 06/16/2012 - 06/19/2012
 - cooke/burnett
- **Assign Chaplain services as necessary for Spiritual needs identified on initial assessment**
 - 06/16/2012 - 06/19/2012
 - Wayne Cooke
- **Assign Hospice Aide service to provide for Personal Care needs**
 - 06/16/2012 - 06/19/2012
 - Jamie Bumgarner
- **Assign RN Case Manager to assess Scope of Service and oversee ongoing patient care needs**
 - 06/16/2012 - 06/19/2012
 - Pam Phipps, RN
- **Assign Social Work to assess for ongoing psychosocial/bereavement/volunteer needs**
 - 06/16/2012 - 06/19/2012
 - Sherry Burnett
- **Collaborate with Attending Physician for Admission orders and obtain Authorization**
 - 06/16/2012 - 06/19/2012
 - Mehta, Sharmila faxed authorization from SRMC Hospice House
- **Collaborate with Hospice Medical Director as necessary for support, Admission orders and obtain Authorization**
 - 06/16/2012 - 06/19/2012
 - R Wentz
- **Collaborate with Interdisciplinary Hospice Team for Team Agreement**
 - 06/16/2012 - 06/19/2012
 - PRN and at IDG
- **Collaborate with Referral Source/Facility/Institution**
 - 06/16/2012 - 06/19/2012
 - faxed records received from SRMCHH
- **Obtain DME/Supplies as needed for patient support**
 - 06/16/2012 - 06/19/2012
 - Allcare
- **Obtain Medication and Treatment Orders - institute immediately**
 - 06/16/2012 - 06/19/2012
 - covered via Hospiscript

Plan Of Care for William F. 102406 at Office Union

Name	Status	Category	Expected Outcome
Alteration in Pulmonary Function	COMPL	NURSE	

- **Adjust temperature and humidity as appropriate**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided
- **Assess for anxiety. Contact MD for possible benzodiazepines as appropriate**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Assess patient's respiratory status at each visit and prn**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN
- **Discuss use of opioids to relieve dyspnea. Obtain MD order and administer as prescribed**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **Evaluate possible cause of dyspnea (COPD exacerbation, thick secretions, anxiety, infection, etc)**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **If currently on opioids, evaluate effectiveness. Notify MD for changes and titrate as ordered**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **O2 as appropriate. Teach PCG appropriate use and when oxygen may be ineffective as disease progresses**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **Provide a draft (use of fans, open window, etc)**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN
- **Reposition for maximum comfort, encourage relaxation techniques**
 - 06/16/2012 - 06/19/2012
 - assessed by & education provided by Lynn Edwards, RN
- **Teach energy conservation techniques to maintain comfort (raise HOB, rest periods during activity, positioning to facilitate air exchange)**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided
- **Teach patient and PCG to call hospice for change in status**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided by BB,RN and Lynn Edwards, RN
- **Teach patient and PCG to elevate HOB as needed to achieve maximum comfort**
 - 06/16/2012 - 06/19/2012
 - assessed by Beth Bailey RN education provided Lynn Edwards, RN

Name	Status	Category	Expected Outcome
Coordination of Care Needs	COMPL	SOCIALWORKER	reviewed 6-19-12 : Collaboration and continuity of care will be maintained as appropriate to the patient/family psychosocial needs.

- **Assess for family/caregiver emotional concerns and psychosocial needs.**
 - 06/17/2012 - 06/19/2012
 -
- **Assess for patient emotional concerns and psychosocial needs.**
 - 06/17/2012 - 06/19/2012
 -
- **Continue communication and collaboration with disciplines providing care to the patient and addressing needs of patient/family**
 - 06/17/2012 - 06/19/2012
 -

Plan Of Care for William F. 102406 at Office Union

Name	Status	Category	Expected Outcome
Coordination of Care Needs	COMPL	CHAPLAIN	Reviewed on 06/19/2012 Collaboration and continuity of care will be maintained as appropriate to the patient/family spiritual needs.

- **Assess for family/caregiver emotional concerns and spiritual needs.**
 - 06/17/2012 - 06/19/2012
 -
- **Assess for patient emotional concerns and spiritual needs.**
 - 06/17/2012 - 06/19/2012
 -
- **Continue communication and collaboration with disciplines providing care to the patient and addressing needs of patient/family**
 - 06/17/2012 - 06/19/2012
 -

Name	Status	Category	Expected Outcome
Difficulty with Grief Process	COMPL	SOCIALWORKER	Reviewed 6-19-12: Patient and Family will be able to demonstrate uncomplicated grief process.

- **Alert bereavement staff to special needs of patient/ family**
 - 06/18/2012 - 06/19/2012
 -
- **Assess family dynamics and how they relate to grief process**
 - 06/18/2012 - 06/19/2012
 -
- **Assess family for anticipatory grief abilities; provide education on anticipatory grief**
 - 06/18/2012 - 06/19/2012
 -
- **Assess for suicide potential/ Ideation**
 - 06/18/2012 - 06/19/2012
 -
- **Encourage and assist patient in life review and preparatory grief**
 - 06/18/2012 - 06/19/2012
 -
- **Explore past losses and coping style**
 - 06/18/2012 - 06/19/2012
 -
- **Other Interventions.**
 - 06/18/2012 - 06/18/2012
 - Gone from my sight book given to family

Plan Of Care for William F. 102406 at Office Union

Name	Status	Category	Expected Outcome
Dying Process	COMPL	NURSE	

- **Assess environment to facilitate peace and dignity**
 - 06/16/2012 - 06/19/2012
 - assessed and appropriate
- **Assess family coping needs**
 - 06/16/2012 - 06/19/2012
 - assessed and needs identified...education provided and on going
- **Assess patient's status(physical, psychosocial, emotional, and spiritual needs)**
 - 06/16/2012 - 06/19/2012
 - assessed
- **Assist with completion of funeral arrangements when appropriate**
 - 06/17/2012 - 06/19/2012
 - initiate discussion when appropriate
- **Communicate signs of impending death and dying. Communicate when changes occur during transition**
 - 06/17/2012 - 06/19/2012
 - Education provided and reinforced
- **Inform physician of patient status as warranted**
 - 06/17/2012 - 06/19/2012
 - MD contacted PCP is out of town
- **Initiate Crisis Care if appropriate**
 - 06/17/2012 - 06/19/2012
 - CC started @ 5:30am
- **Instruct family in patient comfort measures**
 - 06/17/2012 - 06/19/2012
 - Education provided and reinforced
- **Notify appropriate team members**
 - 06/17/2012 - 06/19/2012
 - done
- **Provide emotional support**
 - 06/17/2012 - 06/19/2012
 - emotional and spiritual support provided
- **Provide family with additional support and resources as needed**
 - 06/16/2012 - 06/19/2012
 - Education provided
- **Reinforce education from material(Patient and Family Guide, Gone from My Sight, etc.)**
 - 06/16/2012 - 06/19/2012
 - Sherry Burnett to take Gone From My Sight at initial visit
- **Teach family what to expect at time of death. Assess family roles and willingness to participate in care**
 - 06/16/2012 - 06/19/2012
 - education provided by Lynn Edwards, RN and Beth Bailey, RN

Name	Status	Category	Expected Outcome
Elimination	COMPL	NURSE	

- **Assess current bowel and bladder pattern**
 - 06/16/2012 - 06/19/2012
 - assessed pt has colostomy
- **Assess for effective bowel regimen with stool softener and laxative of choice. Contact MD for orders as needed**
 - 06/16/2012 - 06/19/2012
 - stool softener in place
- **Provide Privacy**
 - 06/16/2012 - 06/19/2012
 -

Plan Of Care for William F. 102406 at Office Union

Name	Status	Category	Expected Outcome
Nutrition/Hydration	COMPL	NURSE	

- **Assess BMI, MAC as appropriate for recertification. Evaluate trends**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey
- **Assess for increased confusion, and/or change in mental status**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey
- **Educate PCG in the effects of disease process on metabolism and appetite**
 - 06/16/2012 - 06/19/2012
 - assessed by and education provided by beth bailey
- **Instruct PCG in oral hygiene**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey

Name	Status	Category	Expected Outcome
Patient Activity Mobility and Safety	COMPL	NURSE	

- **Assess ADL needs encouraging optimal mobility and assist as needed**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey activity adlib
- **Instruct PCG in physical care of the immobilized patient including transfer, ambulation, smoking, safety lighting, etc**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey education provided including no smoking with O2 in use
- **PCG will be instructed in home safety, O2 usage, emergency planning, and safety**
 - 06/16/2012 - 06/19/2012
 - education provided by Lynn Edwards, RN and Allcare Rep
- **Place communication device(s), remotes, phone, snacks, needed items within arms reach**
 - 06/16/2012 - 06/19/2012
 - within reach on overbed table

Name	Status	Category	Expected Outcome
Physical Comfort Alteration	COMPL	NURSE	

- **Assess for effects of unrelieved pain**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey pt able to vocalize pain level
- **Assess pain(level, duration, quality, contributory/alleviating factors, and effects) at each visit and prn**
 - 06/16/2012 - 06/19/2012
 - pt states pain <5 is tolerable
- **Educate caregivers and facility staff on principles of pain management**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Educate caregivers and facility staff to notify hospice nurse of changes in patient's pain management**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Instruct caregivers and facility staff in comfort measures - i.e., massage, bathing, positioning, soft music**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Utilize a numeric pain scale (0-10) consistently. If unable to communicate, utilize the FLACC scale**
 - 06/16/2012 - 06/19/2012
 - pt A&O x3 and able to communicate level of pain

Plan Of Care for William F. 102406 at Office Union

Name	Status	Category	Expected Outcome
Skin Integrity	COMPL	NURSE	

- **Assess skin integrity and effectiveness of skin care each visit**
 - 06/16/2012 - 06/19/2012
 - assessed by beth bailey, rn
- **Evaluate effectiveness of interventions and discuss at IDG. Re-evaluate goals of care as needed**
 - 06/16/2012 - 06/19/2012
 - prn
- **Instruct patient/caregiver in turning and repositioning every two (2) hours**
 - 06/16/2012 - 06/19/2012
 - pt/pcg educated.

Name	Status	Category	Expected Outcome
Spiritual Issues related to Acceptance of Death, and Utilization of Spiritual Resources.	COMPL	CHAPLAIN	Reviewed on 06/19/2012 Patient and family will have their Spiritual needs met.

- **Pray with patient**
 - 06/19/2012 - 06/19/2012
 -

Plan Of Care for William F. 102406 at Office Union

Name	Status	Category	Expected Outcome
Terminal Illness	COMPL	ADMISSION	

- **24-hour availability**
 - 06/16/2012 - 06/19/2012
 - assessed and education provided
- **Admit to hospice on Routine level of care**
 - 06/16/2012 - 06/19/2012
 - transferred from SRMC HH
- **Arrange for equipment as needed/accepted. Specify _____**
 - 06/16/2012 - 06/19/2012
 - See DME list in CTI
- **Arrange for Hospice Aide as needed/accepted**
 - 06/16/2012 - 06/19/2012
 - Jamie Bumgarner
- **Assess patient/family/PCG ability to administer medications**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Assess patient/family/PCG ability to deliver care**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Assess patient/family/PCG understanding of the disease process and care requirements**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Case Manager to manage/coordinate care**
 - 06/16/2012 - 06/19/2012
 - pam phipps
- **Generic drug equivalents many be used**
 - 06/16/2012 - 06/19/2012
 -
- **Instruct patient/family/PCG regarding medication and treatment regimen**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Involve patient/family/PCG in developing plan of care**
 - 06/16/2012 - 06/19/2012
 - IDG invitation provided and encouraged
- **No labs without hospice authorization**
 - 06/16/2012 - 06/19/2012
 - education provided
- **Notify hospice of any changes in condition**
 - 06/16/2012 - 06/19/2012
 - extensive education provided by Beth Bailey, RN and Lynn Edwards, RN
- **Notify Primary MD of patient's admission to hospice. Specify _____**
 - 06/16/2012 - 06/19/2012
 - Sharmila Metha

Union
Care Level ChangesHospice Care
of South Carolina

Mr. William
Name: Hot Shot
ID: 102406
Date of Care: 06/16/2012
Date of Death: 06/19/2012
Status: Deceased
Diagnosis: 162.9 - Malignant neoplasm of bronchus and lung, unspecified
Location:

Copy

Destroy	Description	Effective Date	Level Of Care	Medical Record Number	Office	Location	County	Notes/Reason	Status	RN Initiating Continuous Care
	<u>Discharge - Due to Death</u>	06/19/2012	CONT	102406	Union	Home	Union, SC	TOD 1615 see uploaded CC noted for details	COMPL	
	<u>Change to Continuous Care</u>	06/17/2012	CONT	102406	Union	Home	Union, SC		COMPL	Decrease in BP Increased dyspnea that is non-responsive to oxygen and terminal agitation noted—recorded by Beth Bailey, RN
	<u>New Admission</u>	06/16/2012	ROUTINE	102406	Union	Home	Union, SC	Pt transferred from SRMC HH per patient/family request to his home.	COMPL	

Showing 1 to 3 of 3 entries

[← Previous](#)[Next →](#)

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/16/2012

Discipline
RN

Chart Owner
Bailey, Beth (bbail)

Created By
Bailey, Beth (bbail)

Visit Note

Time Of Event
2045

Visit Note Visit Type
Home *

Note

Visit made to assist and educate CG with administering Morphine push for first time d/t anxiety. Curtis was able to administer it using proper technique and timing, taking 1minute to push morphine 2mg/1mL of morphine. He was able to flush properly and lock clamp back. Family was more at ease after this. Supplies taken for bed bath. Pt tolerated well and had relief of severe dyspnea after 5 minutes of dosing.

Once again family, pt, and CG were educated to call NURSE ON CALL with any questions or in an emergency and were able to verbalize understanding.

Signatures

1. RN Bailey, Beth (User) signed on 06 1 2012. Recorded by beth.bailey on 06/17/2012.

Patient Details for Farr, William 102406

Date Of Birth [REDACTED]	Status Deceased

General Clinical Chart Details**Effective Date**
06/17/2012**Discipline**
Hospice Aide**Chart Owner**
Varner, Dawn (dvarn)**Created By**
Varner, Dawn (dvarn)**Hospice Aide Visit****Hospice Aide Assignment**

Assignment dated
06/16/2012 requested
by Edwards, Lynn for
Aide Bumgarner,
Jamie

Visit Notes

Pt was in bed when I arrived alert but resting on & off had not slept much and was very tired. Doing cont. care visit with pt. He stayed alert during my visit he sipped a few drinks of coffee and wanted a cold rag on his head. His O2 was 85% and he was not in pain during my visit nurse had given him pain med right before I arrived. Pt's sister came and wanted pt to eat and he did eat a 1/2 devil egg and sm piece of ham, and sm piece of pie. Drank about 4oz gatorade and 2oz of water. Pt was tired after eating and wanted to rest he was sleeping when nurse arrived.

Instructions**Hospice Aide Tasks****Activated Tasks****Activity**

Ambulation [Yes], Assist with R.O.M./Exercise [Yes] (not needed), Reposition/Turn Every 2 Hours [Yes], Up In Chair [Yes] (not needed)

Additional Care

Homemaking Activities [Yes], TPR, BP [Yes] (O2 85%)

Dietary

Assist with Meal [Yes], Diet [Yes], Encourage Fluids [Yes] (4oz gatorade, 2oz water, 1oz coffee), Feed [Yes], Food Preparation [Yes]

Elimination

Bathroom with Assistance [Yes], Check Daily Bowel Movement [Yes]

Personal Care

Assist Bed Bath [Yes], Assist with Getting Dressed [Yes], Brush Hair [Yes], Complete Bed Bath [Yes], Denture Care [Yes], Draw Sheet [Yes], Linen Change [Yes], Nail Care [Yes], Oral Hygiene [Yes], Shave [Yes], Shower [Yes], Skin Care [Yes]

Signatures

1. Hospice Aide **Varner, Dawn** (User) signed on **06/22/2012**. Recorded by dawn.varner on 06/22/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date 06/17/2012	Discipline RN	Chart Owner Bailey, Beth (bball)	Created By Bailey, Beth (bball)

Visit Note

Time Of Event 0045	Visit Note Visit Type Home *

Note

Visit made d/t call received from pts daughter c/o pt not being able to breathe, even after PRN medication administered. Upon arrival pt was sitting up on the side of the bed having a very difficult time breathing. CG did not give morphine push, I educated the CG to administer it and watched. Post 5 minutes morphine pt was then placed on the side of the bed leaning over on his over bed table to help with his breathing O2 sats at this time came up from 74% on 16L via NC to 78%. After about 15 minutes pt began to have another spell of very severe dyspnea. At this time CG was questioned and had not given PRN Ativan and was educated to give it SL d/t pt not being able to swallow while having severe dyspnea. Pt reported feeling better 8 minutes post Ativan. At this time pt wanted to lay back in the bed and began c/o pain in his L lower chest. CG at this time gave PRN Oxycontin IR 2 tabs. Pt reported feeling relief after 10 minutes massage and distraction was provided during this time. Pt O2 sat increased to 80%. I sat and comforted pt until family was comfortable with caring for pt and felt crisis was over.

Signatures

1. RN **Bailey, Beth** (User) signed on 06 1 2012. Recorded by beth.bailey on 06/17/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/17/2012

Discipline
RN

Chart Owner
Bailey, Beth (bball)

Created By
Bailey, Beth (bball)

Visit Note

Time Of Event
0530

Call Report
Yes

Visit Note Visit Type
Home *

Note

Crisis Care initiated see hand written notes for further details

Signatures

1. RN **Bailey, Beth** (User) signed on **06/17/2012**. Recorded by beth.bailey on 06/17/2012.



HOSPICE CARE
OF SOUTH CAROLINA

CRISIS CARE ASSESSMENT TOOL

PATIENT NAME: William Farr MEDICAL RECORD #: 102406 COUNTY: Union

Although we cannot predict exactly when a person may die, there are many signs that death may occur within the next few days.

PHYSICAL SYMPTOMS OF AN ACUTE CHANGE IN LEVEL OF CARE

- ☐ Confusion, disorientation, delirium, seizures
- ☒ Pronounced weakness and fatigue
- ☐ Increased drowsiness, sleeping and responsiveness
- ☒ Decreased oral intake
- ☐ Decreased or lack of swallow reflex
- ☐ Surges of energy
- ☒ Restlessness and/or terminal agitation
- ☐ Fever
- ☐ Change in bowel elimination including constipation or diarrhea
- ☒ Incontinence or urinary retention
- ☒ Increase in level of pain per policy on the 1-10 HCSC pain scale Dyspnea
- ☐ Emotional problems such as suicidal ideation, caregiver system breakdown

UNIVERSAL SIGNS OF IMMINENT DEATH

- ☒ Decreased urine output
- ☐ Cold and/or mottled extremities
- ☒ Vital sign changes (10-20mm/HG higher or lower than baseline)
- ☒ Respiratory congestion including respiratory bubbling, severe dyspnea
- ☒ Breathing pattern changes, Cheyne-Stokes, severe dyspnea not responsive to O₂

An assessment of 2 or more physical symptoms of an acute change in the level of care, or 2 or more imminent symptoms should prompt the initiation of crisis care protocol. A Level of Care Change should be noted as 2 or more symptoms in either category which defines an acute change in the patient's Level of Care.

RN SIGNATURE

[Signature]

DATE/TIME

6-17-12 5:30 AM

References: WHO Assessment Ladder of Palliative Care, March 2003
Sharon Kumm, University of Kansas School of Nursing, November 2001
Hospice Care of South Carolina Policy and Procedure Manual



HOSPICE CARE
OF SOUTH CAROLINA

LEVEL OF CARE CHANGE DOCUMENT

PATIENT NAME William Farr MEDICAL RECORD # 102406 COUNTY Union

DATE/TIME OF LEVEL OF CARE CHANGE 6-17-12 5:30am

FROM	TO
ROUTINE q	ROUTINE q
RESPIRE q	RESPIRE q
CRISIS q	CRISIS q
INPATIENT q	INPATIENT q

REASON FOR LEVEL OF CARE CHANGE Decrease in BP, increased dypnea, non re-
non responsive to O2, terminal agitation.

RN SIGNATURE Beth Ballman DATE 6-17-12

DATE	TIME IN	TIME OUT	STAFF NAME/TITLE	TOTAL HOURS
6-17-12	5:30AM	7:00am	Beth Ballman	1.5
6/17/12	7:00AM	12:00	Dawn Dippel	5
6/17/12	12:00	2:55	Beth Ballman	2.95
6/17/12	2:55	4:55	Dawn Dippel	2.00
6/17/12	~~4:55~~ 4:55	9:00	Sandi D. Dwyer RN, C/PW	4.05
6/17/12	9:00pm	12:00AM	Dusan U. McCarty RN, C/PW	3.00
6/18/12	12:00AM	5:20AM	Dusan U. McCarty RN, C/PW	5.25
6/18/12	5:20am	08:30	C. Edwards RN, PCC	3.25
6/18/12	0830	1530	Seisha Motie LPN	7.0
6/18/12	1530	1715	C. Edwards RN, PCC	1.75
6/18/12	1715	2315	Sherrill Allen C/PW	6.0
6/18/12	2315	0200	Sandi D. Dwyer LPN, C/PW	2.75
6/19/12	0200	0630	Zanya Davis LPN	4.5
6/19/12	0630	0830	C. Edwards RN, PCC	2.00
6/19/12	0830	1530	Seisha Motie LPN	7.00

TOTAL HOURS: 58

NON-OVERLAPPING NURSING: _____

NON-OVERLAPPING OTHER: _____

BILLABLE HOURS: 58

REVOKED	q
DISCHARGED	q
TRANSFERRED	q
EXPIRED	q

LEVEL OF CARE CHANGE DOCUMENT

2

COUNTY Union

DATE/TIME OF LEVEL OF CARE CHANGE	6-17-12 5:30 AM

FROM		TO	
ROUTINE	q	ROUTINE	q
RESPITE	q	RESPITE	q
CRISIS	q	CRISIS	q
INPATIENT	q	INPATIENT	q

REASON FOR LEVEL OF CARE CHANGE: Decrease in Bp, increased dyspnea non responsive to O2, terminal agitation

RN SIGNATURE: C. J. [Signature] page continued. DATE: 6-19-12

[illegible]

TOTAL HOURS: .75
NON-OVERLAPPING NURSING: /
NON-OVERLAPPING OTHER: /
BILLABLE HOURS: .75

REVOKED	q
DISCHARGED	q
TRANSFERRED	q
EXPIRED	q

Revised: 11/08



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME:

William Farr

ID #

102406 County Union

DATE	TIME	
6-17-12	5:30am	Visit made d/t call received from family stating that despite PRN medications they are unable to get pt's dyspnea under control. Assisted pt in helpful breathing position. O ₂ @ 16L via oxygenizer & no improvement to dyspnea. Crisis Care initiated at this time. <i>Leah Barton</i>
	6:00am	pt continues to struggle to breathe & all prn meds exhausted at time. BP 124/80 P 124 irreg, RR 40, O ₂ 84% @ 16L, T 96.5 ax. Massage and distraction used to soothe pt. pt drifting in & out of consciousness. <i>Leah Barton</i>
	7:00a	Paramedics present, report given at this time. <i>Leah Barton</i>
	7:00am	Report received from Beth Bailey RN. <i>Leah Barton</i>
	7:00a	pt lying in bed - O ₂ @ 16L via oxygenizer. Resp = 24 & increased resp. effort, chest heaving. Eyes closed, head/neck elevated. Feet & legs warm - pale - no mottling. Wife sitting in recliner @ foot of bed. Fan (ceiling) blowing over bed. <i>Leah Barton</i>
	7:30am	pt with eyes closed, resting @ this time, accessory muscles used to resp. effort - cont on 16L oxygen per oxygenizer. HACC = 1 (re uneasy, tense position) <i>Leah Barton</i>



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: William Farr

ID # 102406 County Union

DATE	TIME	
6-17-12	7:50am	Pt. resting quietly @ this time. Resp. 14 / minute. FIAC = 0. Oxygen sat. @ 16 L/min via (2) oxygen concentrator (older) piggy backed to Y connector. Pt. has oxygen. — Pam Shipp
	7:55am	Med list reviewed. DNR is present on pt's refrigerator. — Pam Shipp
	8:10am	Resp = 16 / min. Resting to O ₂ @ 16 L/min to oxygen sat. Head of bed elevated. Head turning to one side but no nose, no less movement @ this time. — Pam Shipp
	8:30am	Resp. @ 16 / min. Feet are warm — no swelling. — Pam Shipp
	9:00am	Awake, saying "Have mercy." Asked if he could swallow some pills & he nodded. Given Oxygen, Theophylline, Prednisone, Angiotensin, Aliver Vals (2), Celebra Valium Smg (2) Swallowed to small sips of water. Asked for coffee. Drank 1 sip coffee. Pulse = 124, irreg. O ₂ sat 83% on 16 L oxygen to oxygenizer. — Pam Shipp
	9:20am	Eyes closed. Resp increased effort Resp = 20 / min. O ₂ @ 16 L/min. Head of bed elevated. Brother came by to see pt. Wife in room @ foot of bed. Pt. refused food. — Pam Shipp
	9:30am	Resting quietly @ this time. FIAC = 0 down from 7 @ 9am. — Pam Shipp
	9:45am	Daughter awake & voicing concerns that pt. needs to eat. Discussed goals of treatment & her. She states that pt. was removed from hospice house because she did not want pt's life shortened. Talked to her @ length as she discussed pt's life. — Pam Shipp



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

(3)

☒ NURSING ☐ SW ☐ CHAPLAIN

ATTENT NAME: William Van

ID # 102406 County Union

DATE	TIME	
6/17/12	9:30am	W. supine. Eyes closed and resting @ this time. Pam Phlips
	10:10am	Continues to rest quietly. Breathing is even and non-labored @ this time. Pam Phlips
	10:30am	Respirations are 16. Oxygen continues @ 16 L/min with oxymizer. Resting quietly. Hacc scale = 0. Pam Phlips
	11:00 am	Continues a even breathe. Feet are warm to touch. Nothing. Wife @ bedside. Pam Phlips
	11:30am	Respirations 16/min. No restless movement. Oxygen @ 16 L/min. Feet warm. Nothing. Pam Phlips
	11:50pm	Awake grimacing moving restlessly, resp congested. O2 sat 81% on 16 L/min oxygen & oxymizer. Wt given. Oxygenated Nal Sng Yaks (2) po with a sip of water. Resp 18, with chest heaving. Pam Phlips
	12:00pm	Patient restless, moving fast esp, turning head. B/p 120/88 in (R) arm, increased agitation. Pt. heave forth on side. Pam Phlips
	12:00pm	Report given to Beth Butler RN/Pam Phlips
	12:10pm	Pt administered Roxanol 20mg/ml + ml po for severe dyspnea and anxiety. d/t air hunger. Beth Butler
	12:55pm	Pt beginning to calm down & O2 Sats increasing from 74% to 82% pt reports feeling better. Beth Butler
		Pt resting quietly & eyes closed and no S/S of pain or distress per FLACC scale. Beth Butler



CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: William Ferr

ID # 102906 County Union

DATE	TIME	
6-17-12	1:20pm	Pt drowsy but awake to take a sip of coffee. O ₂ Sat 79% c O ₂ @ 16L via oxygenator HC, respiratory condition unstable at bedside. Family refuses atropine d/t drying mucus making it harder for him to breathe so rather help's despite education. <u>Bittman</u>
	1:40pm	Pt continues to rest calmly in & out of consciousness. Responds to speech and touch. Family napping at this time. Lips and finger tips are cyanotic at this time. O ₂ @ 16L via HC Oxygenator. O ₂ Sat 79%. Pt receives comfort feeling the oxygen below in his nostrils and c Rebreather mask pt becomes anxious and pulls mask off. <u>Bittman</u>
	2:25pm	Pt beginning to breathe slower and saying "I need medicine" repeatedly. Renal O.5ml given - per pt request 1/2 dose was given POSE c almost immediate relief noted. <u>Bittman</u>
	2:35pm	Pt reports feeling better, most of pain on distress noted per FLHC scale. <u>Bittman</u>
	2:45pm	Pt beginning to have heavy breathing and request medication. Renal O.5ml



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: William Farr

ID # 102412 County Union

DATE	TIME	
6-17-12	cont cont 2:45pm	given PO/SI. ~~Butter~~
	2:50pm	Pt reports feeling relief and resting calmly c. eyes closed. Dawn Varner, HHA present and report given to her. ~~Butter~~
	3:30	Had company read father's day cards. Resting, pain & breathing under control @ this time cold wet rag on his forehead per pt.
	3:55	O2 sat 85% P118. Sister came feed pt. sister got pt. to eat sm piece of ham & 1/2 deviled egg. sm piece of pie. intake 1/2 cup Gatorade, couple sips of water.
	4:52	Respirations 16/min. Resting pain & breathing seems to be under control @ this time. Dandi, LHA is here gave her reports.
6-17-12	4:55p	Report received from Dawn Varner HHA. P-122 O2 sat 83% on 16 L O2 via nas can. Resp 20 shallow/evens. T 97.3° BP 110/80 Resting with eyes closed. NO SOB. pain per FLACS Babel sounds & ^{normal} lung sounds. Skin w/o color & mottling. Lung sounds congested all lobes. ~~Advey 6:00pm~~
	6:00p	Cont to rest. S/S of pain per FLACS. T-97.6° P-124 rapid/evens Resp 20 shallow/evens. ~~Advey 6:40pm~~



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME:

William Fort

ID #

102406 County Union

DATE	TIME	Cont.
6/17/12	6 ⁰⁰ P	Eyes closed. Turned, repositioned. Briefed by colostomy clean, dry intact. Skin w/ discolor cyanotic, hands dusky O ₂ sat 84% on H ₂ O of O ₂ /nas. can. NO mottling noted. Lung sounds remain to mild congestion all lobes. Wife @ bedside, non-verbal, will not answer questions re the pt or pt by doctor nurse or chaplain
	7 ⁰⁰ P	Opens eyes on assessment. T ₉₉ P-124 R 20 B/P 110/60 O ₂ sat 90% on H ₂ O of O ₂ via nas. can. Pepke Denies pain verbally. Skin w/ cyanotic, hands dusky. NO mottling noted. Cont of mild congestion of all lung fields. No pain per FLACS
	8 P	Turned/repositioned on back T ₉₉ P 124 Resp 20 B/P 110/60 O ₂ sat 84% on H ₂ O of O ₂ sat 84%. No S ₂ of pain per FLACS. Family @ bedside. Skin w/ discolor, cyanotic, hands dusky. Lung sounds congested
	8 ¹⁵ P	Att. small amt ice cream with insulin mix with it 5 difficulty
	9 P	Opens eyes when name is called. Answers questions correctly, drifts back off to sleep. Skin w/ discolor, cyanotic, hands dusky. O ₂ sat 85%



CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: William Ferr

ID # 10246 County Union

DATE	TIME	Cont
6/17/12	9pm	R118 Rts 20 shallow/evens — <u>Sandy K/CHN</u> Report to <u>Dm Curry</u> <u>lpn CHN</u> — <u>Sandy K/CHN</u>
	900pm	hpt. received from <u>Sandi Ivey, lph</u> @ this time, pt sitting up in bed upon my arrival; flacc = 0, pt is — drowsy, but awake and answers — when spoken to, denies pain — verbally; nailbeds cyanotic, pt c circumoral cyanosis; O ₂ in progress @ 16 L via oximixer; exts. warm & dry / hands are cool; BP 122/64, P 118, RR = 18; — <u>Susan U. McCurly lph</u>
	945pm	pt's spouse @ bedside feeding pt. some supper; pt. eats a nearly — full plate of crab and shrimp; pt. had 0 difficulty swallowing; pt. conts. to be drowsy throughout — trying to eat & drink; pt. given his pm meds @ this time as — well. — <u>Susan U. McCurly lph</u>
	1030pm	admin. 0.50ml Roxanol for dyspnea @ this time; pt sts "I feel like — I've fought John Wayne with a — two dollar pistol." pt. offers a — smile & drifts off to sleep; cont.

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 HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME:

William Farr

ID #

102466 County Union

DATE	TIME	
6/17/12	10 ³⁰ pm	to monitor @ bedside, ————— Susan U. McCurry, RN, chapln
	11 ³⁰ pm	pt. resting c̄ & s/sx of pain; RR=16; pt's family also resting in other rooms of the house; L&S warm/dry c̄ & & — mottling. — Susan U. McCurry, RN, chapln
6/18/12	12 ³⁰ am	& Δs c̄ pt. resting peacefully c̄ & s/sx of pain or distress; radial pulse strong @ 114; @ bedside — mon. pt. — Susan U. McCurry, RN chapln
	1 ³⁰ am	repositioned pt. to provide for — better alignment; ↓ HOB slightly due to pt. slumping over; pt. — sts "Thank you." pt. goes directly back to sleep.; — Susan U. McCurry, RN, chapln
	2 ³⁰ am	pt. awakens / able to drink a — few small sips of gatorade via straw; pt. denies pain verbally; pt's RR=20; pulse strong @ 108; — ext. warm; — Susan U. McCurry, RN, chapln
	3 ³⁰ am	pt. conts. to sleep; family is — resting as well; pt. repositioned him- self to (L) side; — Susan U. McCurry, RN chapln



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME:

William Farr

ID #

102416 County Union

DATE	TIME	
6/18/12	4:00am	pt. awakens and removes his O ₂ tubing, sts "I'm ready to go." x 3; pushes this nurse's hand away when trying to replace it; family awake @ bedside & immediately give him ativan and request that an O ₂ mask be placed on him; O ₂ sats checked by son-in-law are @ 73%; p a few mins it ↑ to 78-79%; contacted RN, Lynn Edwards @ this time for support; family is frantic R/t pt's sudden state of terminal agitation; cool cloths are placed on his head; family won't allow pt. to remove his O ₂ ; cyanotic nail beds; RR @ 34; @ bedside offering support to family; Susan U. McCurdy RN Chpn
	5:00am	RN, Lynn arriving @ bedside; RN; Lynn administers 1mL Roxanol R/t verbalized pain @ a 7 on pain scale; pt. ↑ drowsy, but calmer; Susan U. McCurdy RN Chpn



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME:

William Farr

ID #

122446

County

Union

10

DATE	TIME	
6/18/12	0520	Pt Resting 2 eyes Closed. Verbalizes pain @ 5 on scale when asked. States ok at that level. Wife & Sllaw at bedside. Oximeter on R Hand per family @ 83% family has pt on non rebreather which pt attempts to remove. Family at bedside does not allow removal. O2 @ 20L/min. Family Educated about appropriate O2 levels. Family in crisis. Pt verbalizes readiness to die at which point the family panics. This RN & Susan M. LPN @ continuous education to the family. Continue to monitor & educate. ~~Call code blue~~
	0520	rpt. given to RN, Lynn Edwards @ this / this nurse remaining in home for awhile for support; — Susan M. McCurry LPN
	0600	1ml Rocanol administered per FACC score of 8 & labored breathing RR @ 24, O2 83%, HR 136, Apneic periods of 5 seconds noted. Hands mottled. BLE cold to knee level. Cyanosis noted around mouth. Opens eyes to verbal stimulation. ~~Call code blue~~



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: WM. FARR

ID # 10246 County Union

DATE	TIME	
6/18/12	0640	Labored breathing continues at a rate of 16 BPM. Apneic periods of 5-7 seconds noted at times. Breaths are shallow & lungs are congested. Education provided to family concerning O ₂ & what to expect in the dying process. Family to questions concerning nothing noted to hands & knees and education provided. Will continue to monitor. — C. Edwards RN PCC
	0700	Continue Crisis Care. C. Edwards RN PCC
	0710	RR @ 14 BPM, HR @ 137, O ₂ 82%. Pt to 1 labored resp. Lung congested in all fields. Apnea remains sporadic @ 5-7 seconds. ↓ Responsiveness. Occasional moaning noted. Flocc @ 7 on scale. IM Roxanol administered for flocc score & to assist in breathing. C. Edwards RN PCC
	0805	RR @ 11 BPM, HR @ 149, O ₂ @ 82% O ₂ 2L Bismark. Lung sounds - congestion in all lobes & rub in LL. Rte pinpoint pupils. Not responsive to stimuli. Limbs unglacid. Infrequent moan noted. Flocc 6. Respire shallow & labored & infrequent behavior noted. — C. Edwards RN PCC



CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Jim Farr

ID # 102406 County Union

DATE	TIME	
6/18/12	0810	Urine output since this RN's arrival @ 0520. ↓ responsiveness & rattling to hands & ↓ temp to BLE. 1 mL Roxanol administered Rt floor of bed meaning will continue to assess breathing & RR C. Sep. Edwards RN - PCC
	0830	rattling noted to sides of feet. RR @ 24 BPM, HR @ 147, O2 @ 12% O2 20C by bag mask. Resp are ↑ shallow & less accessory muscles used. Barely informed of ↓ status. Barely very distraught & not at bedside. Son-in-law at bed side intermittently. Dtr declines to see father. Very tearful. Continue to monitor C. Sep. Edwards RN - PCC
6/18/12	0830	Report to Julie Delisha Hill - LPN.
	0830	Report received from Lynne Edwards PCC. Arrived at the home and greeted daughter Lisa, son-in-law Kurt and explained duration of stay. Lynne Edwards staying at the bedside due to ↑ family dynamics. Pt is non-responsive to verbal or tactile stimuli. Eyes closed, pupils pinpoint and non-reactive to pinlight. Mouth open. Using accessory muscles to breathe. ↓ air exchange congestion & moan auscultated. O.B.S. O2 has been ↑ by family to 20% ~~by family to 20% O2~~ which (via bag mask)



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Farr, William

ID # 102406 County Union

DATE	TIME	
6/18/12	0830	(cont) is on finger at all times due to family wishes. Has a continual reading of 77%. Brief c/d. Colostomy bag empty, urine empty as well. Skin warm. Watched gastric & cap. refill. Mottling noted to bil. knees & feet (sols). Pulses bounding, neck extended & NVD. Bp - 12/80, P - 145, R - 14, T - 97.8. Face Score = 2. Daughter is not coping at this time. Refuses to come in the same room as her father. Emotional support provided. <u>Jelisha Littlejohn</u>
6/18/12	0910	Lorazepam 0.5mg 2 tabs adm for ↑ HR. Roxanol 0.5ml adm. for face score & dyspnea usage of accessory muscles. — <u>Jelisha Littlejohn</u>
6/18/12	0930	No change in condition. Remains unresponsive to all stimuli. Dtr. cont. to walk around the house but will not come into room — (accessory muscle usage) cont. Will cont. to monitor. Joyce pt's sister as well as Faye called and spoke to Lynne, PCC about sending pt to the hospital and have fluid drawn from lungs. PCC explained pt's cond. — <u>Jelisha Littlejohn</u>
6/18/12	1010	Roxanol 0.5ml/s adm. for accessory muscle usage. Abd. used. Family in a little at a time. Wife in at bedside, non-verbal. Spoke to



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME:

Farr, William

ID # 102400 County Union

DATE	TIME	
6-18-12	1010	(cont) her husband and told him she loved him & that they had good times. His nurse provided emotional support & told her to keep the good memories which will help her through these hard times. — Felicia Little Lpn
6-18-12	1110	HR - 176 very irregular, RR 18 & accessory muscle usage. Color changes, cyanotic hands & ears. Dusky nail beds. Family in front saying their good byes. Circumoral cyanosis. O2 remains 92% min. via ~~nasal cannula~~ ^{nasal mask} Order for 10 L/min. — Felicia Little Lpn
6-18-12	1145	Education pertaining to O2. Some family members accepting of pt's condition some are torn to believe he will turn around & get better. Arms cold, education provided. Sister Joyce asking questions about sending him to get fluid removed from lung. Explained situation & pt status. Breathing very shallow — Felicia Little Lpn
6-18-12	1200	Roxandrosul/SL adm. for atherosclerosis. Will monitor at bedside. Wife wanted to comb pt's hair. Assisted in moving pt's head. Pt cont. to be non-responsive to all stimuli. — Felicia Little Lpn
6-18-12	1200	Wife at bedside & her head laid on pt's shoulder crying. Sister Joyce at bedside, education provided about NVD. Neck stiff nail beds



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Farr, Williams

ID # 102406 County Union

DATE	TIME	
6-18-12	1200	(cont) purple. Gasping audible. Cont to use accessory muscles to breathe. Lynn Edwards PCC in other part of the house providing more education + emotional support to family. Some family members will not come in the same room as pt. ———— <u>Jeisha Little LPN</u> ————
6-18-12	1215	Morphine 3qts adm. per orders for terminal secretions. Pastor arrived + Prayed for pt + Faye, Lisa, Brian + Delores present. SW from HCSC arrived as well. ———— <u>Jeisha Little LPN</u> ————
6-18-12	1245	RR-18 cheyne stoke pattern. Remains unresponsive. Gasping + accessory muscle usage lower abd. muscles used for inadequate air exchange. NVD. Some family remain in other room. All brothers/sisters in home. CC chart reviewed, Face sheet, med list in CC book DNR located on the refrigerator. Previous documentation reviewed. ———— <u>Jeisha Little LPN</u> ————
6-18-12	1245	(+) Roxanol 0.5ml adm. for dyspnea + Fiacc Score = 4. ———— <u>Jeisha Little LPN</u> ————
6-18-12	1315	Bp 72/40, RR-15, HR-114. Skin warm to touch. Family at bedside. + talking at this time. cont on O2 + education provided about secretions + O2 effectiveness. Using accessory muscles. Circumoral cyanosis. Lips cyanotic.



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SVY ☐ CHAPLAIN

162

PATIENT NAME: Farr, William ID # 02400 County Union

DATE	TIME	
6-18-12	1315	(cont) Family emotional & support provided + education as well. ——— ~~Richard K. K. K.~~
6-18-12	1415	Delores is resting on the couch beside pt. Placed soft spiritual music at bedside to help pt relax. HR cont to be ↑. Pt using all muscles to try to breathe. Snoring sound had 5 inspirations. RR-14 = 51 Sec. Apnea noted. Cont. cyanosis. Skin remains warm. Feet mottled. O2 remains on @ 16 L/min. via ~~nasal cannula~~ ^{Baymask} ~~nasal cannula~~ ^{Thorazine} 0.5mg 2 tabs dissolved = Roxanol 0.5mg for pain score of 3, dyspnea. Atropine 3qts adm. for ↑ secretions. Bp 74/52. Checked per request of sister Joyce. ——— ~~Richard K. K. K.~~
6-18-12	1515	RR-11 apnea 57 Sec. Head jacks to the rt. occasionally. Snoring gasp. Using accessory muscles to breathe. Palms + fingertips are darker purple. Sides of feet mottled. Brief c/d. Family at bedside as well as outside. Emotional support + Education cont. to be provided. Family trying to check O2 sat. P-128 O2 Sat 88%. on 16 L/min. via ~~nasal cannula~~ ^{Baymask} ~~nasal cannula~~ ^{Thorazine} 0.5mg 2 tabs dissolved = Roxanol 0.5mg for pain score of 3, dyspnea. Atropine 3qts adm. for ↑ secretions. Bp 74/52. Checked per request of sister Joyce. ——— ~~Richard K. K. K.~~



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Farr, William

ID # 102400 County Union

DATE	TIME	
6-18-12	1530	Report given to Lynn Edwards PCC and spoke of coverage for next shift. ~~Getcha~~ ^{Getcha} ~~Not~~ ^{Not} ~~up~~ ^{up}
6-18-12	1530	Report from Jolisha Bell LPN - ~~Edwards~~ ^{Edwards} PCC
	1555	RR 15BPM, Bottom of feet cyanotic. Resp shallow & periods of apnea @ 5-7 seconds O2 @ 17% on KeL/Bag-Mask. ~~Edwards~~ ^{Edwards} PCC
	1615	Pt & ↑ shallow Resp. shoulder movement noted RR 11 & apnea noted 1ml racumol administered. ~~Edwards~~ ^{Edwards} PCC
	1715	Report to Sherry Allen LPN - ~~Cler~~ ^{Cler} ~~Iden~~ ^{Iden}
6/18/12	1715	Report received from J. Edwards PCC RN Greeted family & explained duration of stay. Sherry Allen CNA
6/18/12	1730	Pt. unresponsive to all stimuli, O2 in place via breathe mask @ 164m, Resp 22 & abd muscles & shoulders used, pupils pinpoint non-reactive to pen light. face pale & cyanotic to oral area, hands & nailbeds cyanotic. cap refill, knees cool, feet pale & nothing to soles, air flow diminished & congestion B/P 66/44, P 142 irreg, T 99.4° ⁵ adult ~~not~~ ^{not} clearly ~~Sherry~~ ^{Sherry} Allen CNA



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Farr, Williams ID # 102406 County Un

DATE	TIME	
6/18/12	1730	(Cont.) Lorazepam 1mg adm. RIT dyspnea ativan 1mg RIT ↑ HR, atropine qts RIT congestion, wife resting on couch next to Pt. who is in hospital bed in livingroom FIM score 0 Sherrill Calkins
6/18/12	1830	Resp 22 shallow & uneven, ↑ cyanosis to hands & fingers, pupils fixed & dilated, skin warm & clammy, & VOF, D2 in place Sherrill Calkins
6/18/12	1900	Resp 24 & abd muscles used & very shallow, Lorazepam 1mg adm. RIT dyspnea, & VOF, ureteral between legs and is empty. Sherrill Calkins
6/18/12	2000	Notified PC Dr. Edwards for the need of RX for ativan 1mg, family states there is no more bottles in home, L. Edwards stated RX will be ready @ CVS in approx. 30 mins. family stated they will be able to pick it up L. All Calkins
6/18/12	2015	atropine qts & Lorazepam 1mg adm as ordered RIT ↑ secretions & dyspnea, Resp 24 shallow uneven & labored Sherrill Calkins



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

19

PATIENT NAME: Farr, William ID # 172476 County UN

DATE	TIME	
6/18/12	2030	Previous notes read, med. list + face sheet in C.C. Chart, DNR listed on face sheet. Skin air circ. adult brief donned, urinal removed, pt repositioned + in bed + to @ side, son states @ side is his favorite, resp became more labored during care, O2 in place. HOB + to assist + comfort + resp. Resp 24 shallow + irreg. Sheri Allen CHN
6/18/12	2200	Notified L. Edwards PCC that family had picked up Ativan and has delivered it to the bedside, also family has a paid private nurse @ the bedside from 9p until 9A. Resp very irreg, 31 P 106/166, P 72 joint + irreg. Sheri Allen CHN
6/18/12	2215	Ativan 1mg adm Jc Roxanol 1ml adm LITO dyspnea + accessory muscles used, nailbeds cyanotic. Dtr states frequently Hosped. house in Sptbg killed this Pt. this nurse listening, Dtr not expecting DX — Sheri Allen CHN



CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: William Farn ID # 102406 County UN

DATE	TIME	
6/18/12	2215	(Cont.) atropine qts 1/11 adm RIT + congestion skin clear after
6/18/12	2315	Resp 22 labored & uneven, O ₂ @ 16 L/min via breathing mask, family @ bedside & pall nurse. Skin clear after
6/18/12	2315	Report given to Sandy Bryant RN Skin clear after
	2255	Report received from S. Allen RN, CHPN - Slight
	2315	Rolinol 1ml given due to resp. difficulty & dyspnea, & accessory muscle use. Nail bed cyanotic. Resp irreg 20 shallow. Pulse 140 apical. B/P 140/60. Upper ext's cool/ dry. Lower ext's warm/pale. O ₂ @ 16 L/min breather. Pt positioned on rt. side only @ family request. Brief clear/dry - Slight/CHPN
	2330	T 100.6 ax - lip cyanotic. Pupils non-reactive Lung sounds congested all fields - Slight/CHPN
6/19/12	0015	Rolinol 1ml given & 3 qts Atropine given for dyspnea, & secretions/congestion. Hands remain cyanotic. Oral cavity cyanotic. Pupils non-reactive. Congestion all lung fields. Upper ext cool to touch, knees cool to touch, Tract's warm. Brief clear/dry Bottom of feet cyanotic. Resp 24 shallow irreg. HOB O ₂ cat @ 16 L/min - breather. Slight/CHPN



CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

-1444-

(21)

PATIENT NAME: Garr, William

ID # 102406 County Union

DATE	TIME	Cont
0045	6/19/12	Resting in hosp. bed c + HOB P. O ₂ @ 16L via re-breather. Pupils non-reactive T-100. 2 ox Pulse 72 irreg radial, unable to hear apical, 140 canoted, irreg. Resp. 24, shallow, c use of accessory muscles. Oral cavity / lips cyanotic, hands & nail beds cyanotic, bottom of feet cyanotic. Upper ext's cool to touch, knees cool to touch, & ext's warm. Unresponsive to all stimuli. Brief clear / dry. Remains on rt side. — Silver G / GPR
6/19/12	0115	Rolinal 1ml given for dyspnea as ordered. Cont on O ₂ . O ₂ sat 80% — Silver G / GPR
	0215	Cont to rest in bed c + HOB P. O ₂ @ 16L via re-breather. O ₂ sat 68% Pulse rate 72 radial irreg. Resp shallow, labored, c use of accessory muscles. Lung fields congested bilat. Rolinal 1ml, Ativan 1mg (18 left in bottle) + Atropine H itts given for dyspnea, ↑ secretions, congestion. Lips, bottom of feet, hands cyanotic. Knees & upper ext's cool to touch. Lower ext's cool to touch. Brief clear / dry. Remains on rt side — Silver G / GPR Report given to Jorge Davis, GPR / GPR Silver G / GPR



(23)

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Jarr, William ID # 102406 County Union

DATE	TIME	
6/19/12	0215	Report received from Sandy Long, LPN/KPNA
	0230	Pt lying in hospital bed in Semi (R) side lying position. Eyes are closed, mouth is shut. O ₂ @ 16L/min & use of oximetry/Hof/Hof rebreather mask. Cyanosis noted around mouth & apex of ear. Resp are uneven & labored. & noted air movement to (R) lung fields. Poor air exchange to RUL. Tended to base. Abdominal musculature to facilitate adequate air exchange. Shoulders are used occasionally. Chest is almost barrel like. C flat abdomen. & note BS to quad x4. Adult brief worn to maintain hygiene incase episodes, brief is clean & dry @ Kristine. But shifts are worn to fresh. Knees are warm. all extremities are cool to touch & the exception, especially warm. D Pedal Pulses: faint to (R) foot, absent to (L) foot. Radial are faint / Unready to palpate. Pt p w/ w on the head adjacent to bed. Proneal pay nurse suties. Pop 6/16 HR 114 RR 100% FLAC - 0. -
		Navis/p
6/19/12	0315	Boxanel 1m/12L given R/T dyspnea & respiratory distress pt unresponsive - Jarr



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Jarr, William ID # 10246 County Union

DATE	TIME	Con't
6/19/2012	0215	before, during & after medication admin. Does not respond to verbal/painful stimuli @ this time. Dgt noted to enter & leave bathroom, but did not enter LR. — Dampyr
	0330	Externally v/poor air exchange. pt's skin to 4 extremities & forehead feel ^{pt's} much "warmer". pt's temp at 6 ^{pt's} 100.4 — Nurse continues to sit @ bedside — Dampyr
6/19	0415	R17 HR120 FLACC ~~pt~~ . Resp uneven/labored & hesitation between breathes. Pt continues to be on O ₂ @ 4 L/min via rebreather mask. Poor air exchange. After approx 7-9 breathes shoulders are involved. Abd muscles used. Pt remains unresponsive to verbal/tactile stimuli. Adult brief warm to touch. Roxanol 1ml/SL given R/T dyspnea, Atropine 1% 3gtts/SL given to & secretions. — Dampyr
6/19	0515	Bp 57/45 HR130 R16 T100.6 @ FLACC ~~pt~~ pt lying & eyes closed. Remains unresponsive. Resp are uneven & labored & true apnea, but hesitation between breathes. Pupils are fixed. Poor air exchange. Continues on O ₂ @ 4 L/min — Dampyr



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Jan, William

ID # 122406 County Union

DATE	TIME	Cont
6/19/12	0515	via rebreather mask. Resp extremely shallow @ times. HR. & palpable radial/pedal pulses. Nail beds cyanotic as well as around mouth. Pt has central line in tact to (L) upper chest, secured & opposite dg. Area is clear. Abdomen flat. Colostomy bag clear & in place to (L) upper quadrant. & BS noted. Adult brief remains clear & dg. Pt hooked & output this shift. Slight mottling to feet (soles). Overall skin is warm to touch. Private nurse remains @ bedside as does pt's wife (as per on ppg. — <i>Marissa</i>)
	0515	Late: Roxanol 1ml/sl given as ordered for dyspnea & respiratory discomfort. — <i>Marissa</i>
6/19/12	0538	Previous documentation reviewed earlier this shift. Face sheet, medical permit in CCU. DNR posted on refrigerator. — <i>Marissa</i>
	0615	Oral care provided for pt prior to medication administration. Roxanol 1ml/sl as ordered for dyspnea. Ativan 1mg/sl as ordered R/T terminal agitation (shoulder involvement). Atropine 1mg qts R/T secretions. Pt unresponsive when care provided. Will continue to monitor. — <i>Marissa</i>



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Farr, William ID # 102406 County Union

DATE	TIME	
6/19/12	0630	Report given to Lynn Edwards, RN - ~~Edwards~~
6/19/12	0630	Report from Tanya Lewis, LPN. Pt resting in bed RR labored, HR 134. Breathing just cyanotic. Pt wants hands ~~C. Edwards~~ PCC
	0715	Pt in terminal agitation & shoulder involved. Resp labored & shallow. 1ml Roxanol administered for resp sp. Pt in secretions around mouth & on pillow. Linen changed & face washed. Watch continued - C. Edwards RN PCC
	0750	Pt repositioned to side using wedges & pillows. All linens changed. RR @ 16 HR @ 134 radial pulse floated. No response from pt to care. C. Edwards RN PCC
	0815	1ml Roxanol administered for ^{labored} respiration & restlessness. C. Edwards RN PCC
	0830	Report to Delisha Bell RN C. Edwards
6/19/12	0830	Report received from Lynn Edwards PCC. Arrived at the home and greeted family and spoke of duration. Greeted PCC and private duty c/g Misty upon entering room & pt. Pt lying on left side (partially) & back & feet supported by pillows. Skin warm. Bil. hands/feet light purple mottling to soles of feet. Nail beds cyanotic & cap. refill. Eyes closed, pupils pinpoint & non-reactive to light. No resistance noted. Mouth



HOSPICE CARE
of SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Jarr, William

ID # 102406 County Union

DATE	TIME	
6-19-12	0830	(cont) Inadequate air exchange, diminished sounds in bases. Usage of lower abd. muscles to breath. Short shallow breaths. Jerks neck up at times while trying to breath. O2 in place @ 16 l/min ^{50% nasal} ~~100% nasal~~ OBS, brief c/d. Colostomy bag clean + intact. Port to LUC has c/d dsq. Intact. Pulses faint. R > L on pedal. Pt is non-responsive to all stimuli. Family is throughout the home. n/d & neck stiff. Face score = 2. Bp - 64/38 HR - 114 Lt. radial, T - 97.8 Temporal, R - 19. — Juliana McKee Lpn —
6-19-12	0915	Roxanol 1ml/SL adm. for ↑ labored breathing & usage of muscles and jerking of neck. — Juliana McKee Lpn
6-19-12	1015	RR - 21 Shoulder + neck involvement & breathing along & abd. muscle usage. Cyanotic around eyes, nose, circumoral. Nails beds + feet remain the same. Face clammy + sweating under O2 mask. Washed face & damp cool cloth + placed on forehead. Playing soft spiritual music @ bedside. Wife resting on couch beside husband. Dtr. not accepting pt's condition. Granddaughter beside this nurse on floor cleaning. Other family throughout the home. ↑ congestion. Roxanol 1ml/SL adm. along & Ativan 1mg for dyspnea and



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: Garr, William

ID # 102406 County Union

DATE	TIME	
6-18-12	1015	(cont) muscle usage. Atropine $\frac{1}{2}$ gHS adm. for ↑ secretions. Has occasional snore when head is turned other than on lt. side. — Jelisha M. Miller —
6-18-12	1115	RR-22, HR-138 apical. Unable to obtain an accurate Bp c manual cuff at this time. Lung fields ~~are~~ still full. WLL, LLL diminished. Hands & nail beds cont. to become darker purple. Brief c/d. Pupils are now 2cm Rt, 3cm Lt. in size. Emotional support provided. Spiritual soft music playing. Son in law verbalized appreciation of music being so nice. Deleones (wife) at bedside playing c grand dtr. and gave her a bath. Still very emotional but coping a little better today. Dtr. not coping. Roxanol 1ml/sc adm. for continual usage of neck and abd. muscles to breathe. — Jelisha M. Miller —
6-18-12	1215	Son that pt raised & took care of (runs his store for him) came by to check on him. Pt. cont. to breathe shallow, short & quick. RR-18 jerks neck & uses abd. muscles. O2 remains in place. Cool cloth on forehead. T-100. Temp. Wife asleep on the couch beside pt. Dtr. Lisa came to the door & asked how he was, I explained about the Bp. Still not accepting father's condition. Roxanol 1ml/sc adm. for dyspnea & muscle usage. — Jelisha M. Miller —



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: William, Farr ID # 102406 County Union

DATE	TIME	
6-18-12	1215	Late entry adm. Oral care prior to adm. Roxanol. c damp Swab. Pt closed mouth and bit on sponge several times. Removed med. amt. of thick matter. Applied lip moisturizer due to dryness. Wiped face, neck, bil. arms + legs, feet c cool damp cloth to assist c v damp ~~bedsheet~~ ~~bedsheet~~
6-18-12	1315	HR-140, RR-20. NVD, pale face. Hands + feet remain the same. Skin warm. Brief c/d. Pulses palpable but faint and hard to obtain pulse. Repositioned pt more on lt. side c wedge behind back. Cont. to jerk neck up c abd. muscle c every effort to breath. Enc. wife to let the family get her some lunch but refused. Drinking water. Laying on the couch. Does interact c grand daughter comes into room. DTR. still not accepting or coping well when told of any changes. Roxanol 1ml/sl given for symptoms. <u>Jillha Little Lpr</u>
6-18-12	1415	Pt remains the same. Wife did go into kitchen c her sister to eat lunch. Cont. to breath c muscles + neck stiff. NVD. Pale RR-20. Short quick + shallow. HR-140. Rales auscultated in ~~PLH~~ ^{CPAles} . Hands + feet remain the same. Soles of feet mottled + bil. knees mottled and turning cool. Roxanol 1ml/sl adm. for air hunger + Atropine <u>gts for 1 Secretions.</u> <u>Jillha Little Lpr</u>



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ NURSING ☐ SW ☐ CHAPLAIN

PATIENT NAME: William, Farr

ID # 102400 County Union

DATE	TIME	
6-18-12	1515	Unable to obtain an accurate BP at this time. HR-145 (apical) RR-16-Short, quick, shallow, T-102.0 Cool cloth being rubbed all over body by sister Joyce. Family at bedside at this time. Mottling cont. to feet + knees, hands (palms) feet + knees are cooling. Nailbeds purple. Face cyanotic circumoral cyanosis. Eye orbits dark. Mouth open, eyes closed. Pupils dilated but non-reactive. Brief SpO_2 80% on Bm this shift. Uses accessory muscles + effort to breathe. O2 remains on @ 16 L/min via bagmask. Roxanol 1ml/4 + Ativan 1mg adm. for symptoms noted. ~~Relisha Hill LPN~~
6-18-12	1530	Report given to Lynn Edwards RNC - ~~Relisha Hill LPN~~
6-19-12	1530	Report from Jelesha Hill LPN - ~~Relisha Hill LPN~~
	1545	Family at bedside of bed. BP 40/0 Repr 11% shallow. — ~~Relisha Hill LPN~~
	1605	Terminal Secretions noted from mouth & nose after deep breath keep at 4/min monitoring continuously Pt & bed cleaned.
	1613	No respirations noted HR @ 22 BPM ~~Relisha Hill LPN~~
	1615	Unable to assess any VS TOD assessed. ~~Relisha Hill LPN~~ Sister at bedside. Family out on dial notified. Normal grieving noted except dtr who left for home on foot & has not returned. Continue to monitor & prep family. ~~Relisha Hill LPN~~



HOSPICE CARE
OF SOUTH CAROLINA

CLINICAL NOTE

☒ ~~NURSING~~ ☐ SW ☐ CHAPLAIN

PATIENT NAME: Jam, William ID # 102406 County Union

[illegible]

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/17/2012

Discipline
RN

Chart Owner
Phipps, Pam (pphip)

Created By
Phipps, Pam (pphip)

Visit Note

Time Of Event
0700

Visit Note Visit Type
Home *

Note

Crisis care visit- see written crisis care notes.

Signatures

1. RN Phipps, Pam (User) signed on 06 1 2012. Recorded by pam.phipps on 06/17/2012.

Patient Details for Farr, William 102406

Date Of Birth [REDACTED]	Status Deceased

General Clinical Chart Details

Effective Date
06/17/2012

Discipline
RN

Chart Owner
Bailey, Beth (bbail)

Created By
Bailey, Beth (bbail)

Visit Note

Time Of Event
1200

Visit Note Visit Type
Home *

Note

Continuous Care visit see hand written notes

Signatures

1. RN **Bailey, Beth** (User) signed on **06 1 2012**. Recorded by beth.bailey on 06/18/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/17/2012

Discipline
LPN/LVN

Chart Owner
Ivey, Sandra (sivey)

Created By
Ivey, Sandra (sivey)

Visit Note

Time Of Event
1655

Visit Note Visit Type
PRN *

Note
Crisis Care Visit

Signatures

1. LPN/LVN **Ivey, Sandra** (User) signed on **06/17/2012**. Recorded by sandi.ivey on 06/17/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/17/2012

Discipline
Social Services

Chart Owner
Burnett, Sherry
(sburn)

Created By
Burnett, Sherry
(sburn)

Visit Note

Time Of Event
2000

Visit Note Visit Type
Phone Call

Note

Sw contacted family after being notified earlier today by Beth Bailey that patient had been started on crisis care. Daughter strong in her faith, still in denial. Sw offered emotional support and encouragement. Sw gave phone number in the event that family wanted a visit before monday from social worker.

Signatures

1. Social Services **Burnett, Sherry** (User) signed on **06 1 2012**. Recorded by sherry.burnett on 06/17/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
LPN/LVN

Chart Owner
McCurry, Susan
(smccu)

Created By
McCurry, Susan
(smccu)

Signatures

1. LPN/LVN **McCurry, Susan** (User) signed on **06/18/2012**. Recorded by susan.mccurry on 06/18/2012.

Consolo RN Clinical Chart by Edwards, Lynn Dated 06/18/2012 (9855019)

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Nursing Summary

Nursing Summary Notes

Visit Notes

0416 call received from Susan M, LPN stating family was in crisis over patients declining condition and she needed help managing the situation.

0445 arrived at pts home spoke with family Susan M, Managed patient while this RN calmed family and spent time counseling family
remained at home with family until my CC shift began

Signatures

1. RN **Edwards, Lynn** (User) signed on **06/19/2012**. Recorded by lynn.edwards on 06/19/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details**Effective Date**

06/18/2012

Discipline

Social Services

Chart OwnerBurnett, Sherry
(sburn)**Created By**Burnett, Sherry
(sburn)**Bereavement Assessment****Name**

Farr, Dolores

Other Family**Other Significant Family Members**

Lisa, daughter is in denial. wife Delores, suffered a breakdown and has not spoken to anyone except family on rare occasions in ten years.

How will the bereaved cope?

Doubtful, may need special help

Comments

Lisa, daughter, is in denial. She is having a difficult time with accepting her father's prognosis. Unusual family dynamics may cause difficulty with bereaved.

Social Assessment**Mental Status**

Unable to assess. Patient unresponsive to others today. He is receiving crisis care. Sw unable to obtain initial information due to patient actively dying and family upset and at bedside. Patient was able to eat crab legs last night per family. He loves seafood.

Primary Care Giver

Farr, Dolores

Symptoms

Other (unable to assess. Patient on crisis care)

Appearance

Well Groomed

Motor Activity

Other (unable to assess)

Affect

Other (unresponsive)

Mood

Other (unable to assess)

Speech

Other (unable to assess)

Thought Process

Other (unable to assess)

Hallucinations

Other (unable to assess)

Delusions

Other (unable to assess)

Memory

Other (unable to assess)

Judgment

Other (unable to assess)

Insight

Other (unable to assess)

Intelligence

Other (unable to assess)

History

Mental Health History

unable to obtain information as patient is on crisis care and family at bedside

Substance Abuse History/Issues

unable to assess

Family History

Patient has two children, wife, and siblings. They are all at bedside as patient is unresponsive and receiving crisis care.

Cultural History or Barrier That Affects Care

n/a

Educational History

unable to obtain.

Work History

unable to obtain.

Hobbies/Interests

yard work

How is the patient coping with the illness?

unable to assess

What is the hardest part of illness for the patient?

unable to assess

Financial And Legal Information

Financial Concerns

n/a

Financial Comments

n/a

Family Information

Family Coping

Patient wife does not speak to others, she may verbalize to family on occasion. She had a breakdown about ten years ago. Patient has two children, daughter, Lisa, is in denial. She is having a really difficult time accepting her father's condition. Unable to assess pcg, wife, as she does not speak, she just sits by patient's side and looks, or cries.

Family Dynamics

Patient daughter in denial. Pcg has mental illness/does not talk to others.

Primary Care Giver's Evaluation

How is caregiver coping with role?

family is not coping well at this time.

Assessment of caregiver's grief

difficulty with grief noted with family

Social Worker Assessment

Patient has supportive family, but they are not accepting of patient's illness/prognosis. They are having a difficult time.

Signatures

1. Social Services **Burnett, Sherry** (User) signed on **06/18/2012**. Recorded by sherry.burnett on 06/18/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Nursing Summary

Nursing Summary Notes

Visit Notes

0645-0830 Crisis Care Coverage

Patient/Family/Representative/CG Goals

family dynamics....difficulty with teaching family EOL sx and mgt....

Signatures

1. RN Edwards, Lynn (User) signed on 06/19/2012. Recorded by lynn.edwards on 06/19/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
Chaplain

Chart Owner
Cooke, Wayne (wcook)

Created By
Cooke, Wayne (wcook)

Bereavement Assessment

Other Family

Other Significant Family Members

Wife Delores

How will the bereaved cope?

Doubtful, may need special help (Wife would not talk to Chaplain. Chaplain thinks the daughter is in denial.)

Comments

Wife was sitting in the room with the patient. She would not talk. Daughter kept saying that her father was going to get better. Patient was on Crisis Care during assessment visit.

Spiritual Assessment

Significant Others in Patient's Life: Wife Delores, Religious Utilization: Patient was admitted on Saturday, June 16. Patient was placed on Crisis Care on Sunday. Chaplain was unable to complete Spiritual assessment during to patient's illness. Because of patient's condition, Chaplain was unable to talk with the family., Comments: Patient was on Crisis care when Chaplain went to home to complete Spiritual assessment. Due to patient's condition, Chaplain was unable to complete assessment.

Signatures

1. Chaplain **Cooke, Wayne** (User) signed on **06/18/2012**. Recorded by wayne.cooke on 06/18/2012.

Consolo LPN/LVN Clinical Chart by Curtis, Felisha Dated 06/18/2012 (9839158)

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
LPN/LVN

Chart Owner
Curtis, Felisha (fcurt)

Created By
Curtis, Felisha (fcurt)

Signatures

1. LPN/LVN Hill, Felisha (User) signed on 06/18/2012. Recorded by felisha.hill on 06/18/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
LPN/LVN

Chart Owner
Ivey, Sandra (sivey)

Created By
Ivey, Sandra (sivey)

Visit Note

Time Of Event
1055

Visit Note Visit Type
LPN/LVN On Call Notes

Note
Crisis Care Visit

Signatures

1. LPN/LVN Ivey, Sandra (User) signed on 06/18/2012. Recorded by sandi.ivey on 06/18/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
LPN/LVN

Chart Owner
Allen, Sherri (salle)

Created By
Allen, Sherri (salle)

Signatures

1. LPN/LVN **Allen, Sherri** (User) signed on **06/19/2012**. Recorded by sherri.allen on 06/19/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Nursing Summary**Nursing Summary Notes****Visit Notes**

remained at home through the day r/t family dynamics and education of family and deescalation of family members....continuous education provided mr/t EOL care, symptoms, management of symptoms

Family/Representative/CG Willingness and Capability to Care For Patient**Concerns**

Yes

Comments

many concerns including medication symptoms EOL

Signatures

1. RN Edwards, Lynn (User) signed on **06/19/2012**. Recorded by lynn.edwards on 06/19/2012.

Patient Details for Farr, William 102406

Date Of Birth [REDACTED]	Status Deceased

General Clinical Chart Details

Effective Date
06/18/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Signatures

1. RN **Edwards, Lynn** (User) signed on **06/19/2012**. Recorded by lynn.edwards on 06/19/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/19/2012

Discipline
LPN/LVN

Chart Owner
Ivey, Sandra (sivey)

Created By
Ivey, Sandra (sivey)

Signatures

1. LPN/LVN **Ivey, Sandra** (User) signed on **06/19/2012**. Recorded by sandi.ivey on 06/19/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/19/2012

Discipline
LPN/LVN

Chart Owner
Curtis, Felisha (fcurt)

Created By
Curtis, Felisha (fcurt)

Signatures

1. LPN/LVN Hill, Felisha (User) signed on 06/19/2012. Recorded by felisha.hill on 06/19/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/19/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Signatures

1. RN Edwards, Lynn (User) signed on **06/19/2012**. Recorded by lynn.edwards on 06/19/2012.

Consolo RN Clinical Chart by Edwards, Lynn Dated 06/19/2012 (9855149)

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details**Effective Date**
06/19/2012**Discipline**
RN**Chart Owner**
Edwards, Lynn (ledwa)**Created By**
Edwards, Lynn (ledwa)**Signatures**

1. RN Edwards, Lynn (User) signed on **06/19/2012**. Recorded by lynn.edwards on 06/19/2012.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/19/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Signatures

1. Skilled Nurse **Edwards, Lynn** (User) signed on **03/05/2013**. Recorded by lynn.edwards on 03/05/2013.

Addendums

Date	Signed By	Reason	Section Note
03/05/2013 09:26 EST	Edwards, Lynn (ledwa)	Corrected Information	Chart signed late r/t discovery of unsigned chart during routine chart audit.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/19/2012

Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Signatures

1. Skilled Nurse **Edwards, Lynn** (User) signed on **03/05/2013**. Recorded by lynn.edwards on 03/05/2013.

Addendums

Date	Signed By	Reason	Section Note
03/05/2013 09:25 EST	Edwards, Lynn (ledwa)	Corrected Information	Chart signed late r/t discovery of unsigned chart during routine chart audit.

Patient Details for Farr, William 102406

Date Of Birth		Status	Deceased

General Clinical Chart Details

Effective Date
06/19/2012

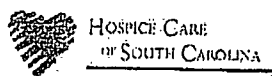
Discipline
RN

Chart Owner
Edwards, Lynn (ledwa)

Created By
Edwards, Lynn (ledwa)

Signatures

1. RN Edwards, Lynn (User) signed on 06/19/2012. Recorded by lynn.edwards on 06/19/2012.



PHYSICAL PAIN MANAGEMENT TOOL

 PATIENT NAME: William Jarr

 ID#: 102406

 DATE/TIME: 6/17/12 9AM
☒ INITIAL ASSESSMENT

☐ ADMISSION COMPREHENSIVE ASSESSMENT

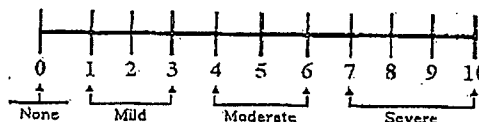
☐ COMPREHENSIVE ASSESSMENT UPDATE

☐ OTHER

PAIN GOAL: _____

 PAIN SCALES:
(Select one and identify pain score)

 0-10 NUMERIC: ☐

 FLACC: ☒


INDICATE INTENSITY, DURATION AND QUALITY BY EACH LOCATION BELOW:

LOCATION	DURATION	QUALITY	WHAT MAKES PAIN BETTER?	WHAT MAKES PAIN WORSE?	EFFECTS OF PAIN
 1	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other
 2	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other
 3	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other

PAIN INTERVENTION AND RE-EVALUATION					
INTERVENTIONS				RE-EVALUATION	
Time	Pain Score	Analgesia	Dose, Route	*Other Measures	Time
9:00am	7	Oxycotin 10mg	po		9:30am
		Ativan 0.5mg			
		Hydro(2)			

*Other Measures Key: A = Aromatherapy, C = Cold, H = Heat, MSG = Massage, MUS = Music, P = Position/Reposition, R = Rest, O = Other (Identify in Note)

☐ REFER TO NARRATIVE CLINICAL NOTE

 Nurse Signature: Pam Phibes

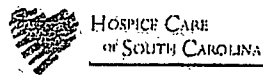
 Title: RN

FLACC PAIN SCALE:

- SUM OF FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY = SCORE
- RECORD FLACC SCORES USING THE 0-10 (NUMERIC) SCALE ABOVE.

Face	2	0 = No particular expression or smile. 1 = Occas. grimace or frown, withdrawn, disinterested 2 = Freq. - constant frown, clenched jaw, quivering chin
Legs	1	0 = Normal position or relaxed 1 = Uneasy, restless, tense 2 = Kicking or legs drawn up
Activity	2	0 = Lying quietly, normal position, moves easy 1 = Squirming, shifting back & forth, tense 2 = Arched, rigid or jerking
Cry	1	0 = No crying (asleep or awake) 1 = Moans or whimpers, occasional complaint 2 = Crying steadily, screams or sobs, freq. complaints
Consolability	1	0 = Content, relaxed 1 = Reassured by touching, hugging, talking, distractible 2 = Difficult to console or comfort

 TOTAL SCORE: 7



PHYSICAL PAIN MANAGEMENT TOOL

PATIENT NAME: Farr, William ID#: 102406 DATE/TIME: 6/17/12 @ 9:00 pm

☒ INITIAL ASSESSMENT ☐ ADMISSION COMPREHENSIVE ASSESSMENT ☐ COMPREHENSIVE ASSESSMENT UPDATE ☒ OTHER

PAIN GOAL: <u>0</u>	PAIN SCALES: (Select one and identify pain score)	0-10 NUMERIC: ☒ <u>0</u>	
	FLACC: ☐	pt. able to verbalize	

INDICATE INTENSITY, DURATION AND QUALITY BY EACH LOCATION BELOW:

LOCATION	DURATION	QUALITY	WHAT MAKES PAIN BETTER?	WHAT MAKES PAIN WORSE?	EFFECTS OF PAIN
 1	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other
 2	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other
 3	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other

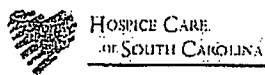
PAIN INTERVENTION AND RE-EVALUATION				
INTERVENTIONS				RE-EVALUATION
Time	Pain Score	Analgesia	Dose, Route	*Other Measures

*Other Measures Key: A = Aromatherapy, C = Cold, H = Heat, MSG = Massage, MUS = Music, P = Position/Reposition, R = Rest, O = Other (Identify in Note)

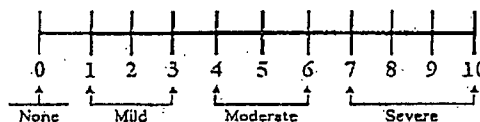
☒ REFER TO NARRATIVE CLINICAL NOTE

Susan H. McCarty CPNP, CHPN
Nurse Signature Title

FLACC PAIN SCALE:	
1. SUM OF FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY = SCORE	
2. RECORD FLACC SCORES USING THE 0-10 (NUMERIC) SCALE ABOVE	
Face	0 = No particular expression or smile 1 = Occas. grimace or frown, withdrawn, disinterested 2 = Freq. - constant frown, clenched jaw, quivering chin
Legs	0 = Normal position or relaxed 1 = Uneasy, restless, tense 2 = Kicking or legs drawn up
Activity	0 = Lying quietly, normal position, moves easily 1 = Squirming, shifting back & forth, tense 2 = Arched, rigid or jerking
Cry	0 = No crying (asleep or awake) 1 = Moans or whimpers, occasional complaints 2 = Crying steadily, screams or sobs, frequent complaints
Consolability	0 = Content, relaxed 1 = Reassured by touching, hugging, talking, distractible 2 = Difficult to console or comfort
TOTAL SCORE	



PHYSICAL PAIN MANAGEMENT TOOL

PATIENT NAME: Farr, WilliamID#: 102406DATE/TIME: 6-18-12 830☒ INITIAL ASSESSMENT☐ ADMISSION COMPREHENSIVE ASSESSMENT☐ COMPREHENSIVE ASSESSMENT UPDATE☐ OTHERPAIN GOAL: 0PAIN SCALES:
(Select one and
identify pain score)0-10 NUMERIC: ☐FLACCS: ☒

INDICATE INTENSITY, DURATION AND QUALITY BY EACH LOCATION BELOW:

RIGHT	LEFT	LOCATION	DURATION	QUALITY	WHAT MAKES PAIN BETTER?	WHAT MAKES PAIN WORSE?	EFFECTS OF PAIN
		1	☐ Occasional ☐ Frequent ☐ Constant ☐ _____	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing ☐ _____	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other _____
		2	☐ Occasional ☐ Frequent ☐ Constant ☐ _____	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing ☐ _____	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other _____
		3	☐ Occasional ☐ Frequent ☐ Constant ☐ _____	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing ☐ _____	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other _____

Circle location on body diagram and identify with number

PAIN INTERVENTION AND RE-EVALUATION					
INTERVENTIONS				RE-EVALUATION	
Time	Pain Score	Analgesia	Dose, Route	*Other Measures	Time Pain Score
0910	2	Roxanol	0.5ml	R/P	1010 4
1010	4	Roxanol	0.5ml	R/P	1110 4
1145	4	Roxanol	0.5ml	R/P	1245 4
1415	3	Roxanol	0.5ml	R	

*Other Measures Key: A = Aromatherapy, C = Cold, H = Heat, MSG = Message, MUS = Music, P = Position/Reposition, R = Rest, O = Other (Identify in Note)

REFER TO NARRATIVE CLINICAL NOTE

Kelisa J. Feller
Nurse Signature

Lpn
Title

FLACCS PAIN SCALE:

1. SUM OF FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY = SCORE
2. RECORD FLACC SCORES USING THE 0-10 (NUMERIC) SCALE ABOVE

Face	<u>0</u>	0 = No particular expression or smile 1 = Occas. grimace or frown, withdrawn, disinterested 2 = Freq. - constant frown, clenched jaw, quivering chin
Legs	<u>0</u>	0 = Normal position or relaxed 1 = Uneasy, restless, tense 2 = Kicking or legs drawn up
Activity	<u>1</u>	0 = Lying quietly, normal position, moves easy 1 = Squirming, shifting back & forth, tense 2 = Arched, rigid or jerking
Cry	<u>1</u>	0 = No crying (asleep or awake) 1 = Moans or whimpers, occasional complaint 2 = Crying steadily, screams or sobs, freq. complaints
Consolability	<u>0</u>	0 = Content, relaxed 1 = Reassured by touching, hugging, talking, distractible 2 = Difficult to console or comfort
<u>2</u>		TOTAL SCORE



PHYSICAL PAIN MANAGEMENT TOOL

PATIENT NAME: William Farr

ID#: 102406

DATE/TIME: 6/18/12 5:30p

☒ INITIAL ASSESSMENT

☐ ADMISSION COMPREHENSIVE ASSESSMENT

☐ COMPREHENSIVE ASSESSMENT UPDATE

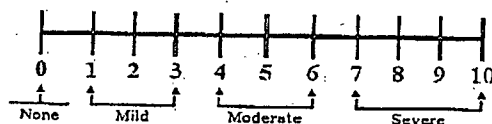
☒ OTHER

PAIN GOAL: 0

PAIN SCALES:
(Select one, and identify pain score)

0-10 NUMERIC: ☐

FLACCS: ☒ 0



INDICATE INTENSITY, DURATION AND QUALITY BY EACH LOCATION BELOW:

LOCATION	DURATION	QUALITY	WHAT MAKES PAIN BETTER?	WHAT MAKES PAIN WORSE?	EFFECTS OF PAIN
RIGHT LEFT	☐ Occasional ☐ Frequent ☐ Constant ☐ _____	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing ☐ _____	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other _____
LEFT RIGHT	☐ Occasional ☐ Frequent ☐ Constant ☐ _____	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing ☐ _____	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other _____
LEFT RIGHT Circle location on body diagram and identify with number	☐ Occasional ☐ Frequent ☐ Constant ☐ _____	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing ☐ _____	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other _____

PAIN INTERVENTION AND RE-EVALUATION					
INTERVENTIONS					RE-EVALUATION
Time	Pain Score	Analgesia	Dose, Route	*Other Measures	Time Pain Score

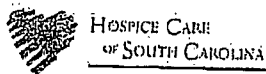
*Other Measures Key: A = Aromatherapy, C = Cold, H = Heat, MSG = Massage, MUS = Music, P = Position/Reposition, R = Rest, O = Other (Identify in Note)

☒ REFER TO NARRATIVE CLINICAL NOTE

Shen Allen
Nurse Signature

CHPL
Title

FLACCS PAIN SCALE:	
1. SUM OF FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY = SCORE	
2. RECORD FLACCS SCORES USING THE 0-10 (NUMERIC) SCALE ABOVE	
Face <u>0</u>	0 = No particular expression or smile 1 = Occas. grimace or frown, withdrawn, disinterested 2 = Freq. - constant frown, clenched jaw, quivering chin
Legs <u>0</u>	0 = Normal position or relaxed 1 = Uneasy, restless, tense 2 = Kicking or legs drawn up
Activity <u>0</u>	0 = Lying quietly, normal position, moves easy 1 = Squirming, shifting back & forth, tense 2 = Arched, rigid or jerking
Cry <u>0</u>	0 = No crying (asleep or awake) 1 = Moans or whimpers, occasional complaint 2 = Crying steadily, screams or sobs, freq. complaints
Consolability <u>0</u>	0 = Content; relaxed 1 = Reassured by touching, hugging, talking, distractible 2 = Difficult to console or comfort
<u>0</u>	TOTAL SCORE



PHYSICAL PAIN MANAGEMENT TOOL

PATIENT NAME: Jarr, William

ID#: 102400

DATE/TIME: 06/19/2012-0800

☒ INITIAL ASSESSMENT

☐ ADMISSION COMPREHENSIVE ASSESSMENT

☐ COMPREHENSIVE ASSESSMENT UPDATE

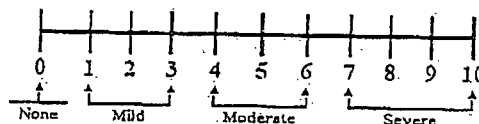
☒ OTHER

PAIN GOAL: L3

PAIN SCALES:
(Select one and identify pain score)

0-10 NUMERIC: ☐

FLACCS: ☒



INDICATE INTENSITY, DURATION AND QUALITY BY EACH LOCATION BELOW:

LOCATION	DURATION	QUALITY	WHAT MAKES PAIN BETTER?	WHAT MAKES PAIN WORSE?	EFFECTS OF PAIN
1	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other
2	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other
3	☐ Occasional ☐ Frequent ☐ Constant	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other

PAIN INTERVENTION AND RE-EVALUATION					
INTERVENTIONS					RE-EVALUATION
Time	Pain Score	Analgesia	Dose, Route	*Other Measures	Time Pain Score

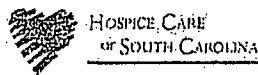
*Other Measures Key: A = Aromatherapy, C = Cold, H = Heat, MSG = Message, MUS = Music, P = Position/Reposition, R = Rest, O = Other (Identify in Note)

REFER TO NARRATIVE CLINICAL NOTE

Zenya Davis
Nurse Signature

lpn
Title

FLACCS PAIN SCALE:	
1. SUM OF FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY = SCORE	
2. RECORD FLACC SCORES USING THE 0-10 (NUMERIC) SCALE ABOVE:	
Face	0 = No particular expression or smile 1 = Occas. grimace or frown, withdrawn, disinterested 2 = Freq. - constant frown, clenched jaw, quivering chin
Legs	0 = Normal position or relaxed 1 = Uneasy, restless, tense 2 = Kicking or legs drawn up
Activity	0 = Lying quietly, normal position, moves easy 1 = Squirming, shifting back & forth, tense 2 = Arched, rigid or jerking
Cry	0 = No crying (asleep or awake) 1 = Moans or whimpers, occasional complaint 2 = Crying steadily, screams or sobs, freq. complaints
Consolability	0 = Content, relaxed 1 = Reassured by touching, hugging, talking, distractible 2 = Difficult to console or comfort
TOTAL SCORE	

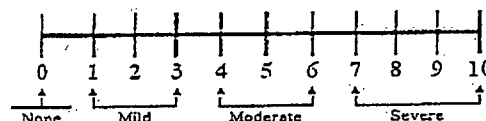


PHYSICAL PAIN MANAGEMENT TOOL

 PATIENT NAME: Jarr, William ID#: 102406 DATE/TIME: 6-19-12 830am
☒ INITIAL ASSESSMENT

☐ ADMISSION COMPREHENSIVE ASSESSMENT

☐ COMPREHENSIVE ASSESSMENT UPDATE

☐ OTHER
PAIN GOAL: 0
 PAIN SCALES:
(Select one and
identify pain score)
0-10 NUMERIC: ☐FLACCS: ☒

INDICATE INTENSITY, DURATION AND QUALITY BY EACH LOCATION BELOW:

LOCATION	DURATION	QUALITY	WHAT MAKES PAIN BETTER?	WHAT MAKES PAIN WORSE?	EFFECTS OF PAIN
RIGHT LEFT	☐ Occasional ☐ Frequent ☐ Constant <u>1</u>	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing <u>1</u>	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other
LEFT RIGHT	☐ Occasional ☐ Frequent ☐ Constant <u>2</u>	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing <u>2</u>	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other
3 Circle location on body diagram and identify with number	☐ Occasional ☐ Frequent ☐ Constant <u>3</u>	☐ Sharp ☐ Dull ache ☐ Throbbing ☐ Tingling ☐ Burning ☐ Stabbing <u>3</u>	☐ Rest ☐ Meds ☐ Reposition ☐ Massage ☐ Heat ☐ Ice ☐ Sleep ☐ Spiritual Support	☐ Activity ☐ Rotation ☐ Noise ☐ Light ☐ Heat ☐ Ice	☐ None ☐ Nausea ☐ Sleep ☐ Appetite ☐ Physical activity ☐ Relationship with others (irritability, etc.) ☐ Emotions (anger, crying, suicidal, etc.) ☐ Concentration ☐ Other

PAIN INTERVENTION AND RE-EVALUATION					
INTERVENTIONS					RE-EVALUATION
Time	Pain Score	Analgesia	Dose, Route	*Other Measures	Time Pain Score

*Other Measures Key: A = Aromatherapy, C = Cold, H = Heat, MSG = Massage, MUS = Music, P = Position/Reposition, R = Rest, O = Other (Identify in Note)

☒ REFER TO NARRATIVE CLINICAL NOTE

Seelisha Motie
Nurse Signature

Lpn
Title

FLACCS PAIN SCALE:

1. SUM OF FACE, LEGS, ACTIVITY, CRY & CONSOLABILITY = SCORE.
-
2. RECORD FLACC SCORES USING THE 0-10 (NUMERIC) SCALE ABOVE

Face	<u>0</u>	0 = No particular expression or smile 1 = Occas. grimace or frown, withdrawn, disinterested 2 = Freq. - constant frown, clenched jaw, quivering chin
Legs	<u>0</u>	0 = Normal position or relaxed 1 = Uneasy, restless, tense 2 = Kicking or legs drawn up
Activity	<u>2</u>	0 = Lying quietly, normal position, moves easy 1 = Squirming, shifting back & forth, tense 2 = Arched, rigid or jerking
Cry	<u>0</u>	0 = No crying (asleep or awake) 1 = Moans or whimpers, occasional complaint 2 = Crying steadily, screams or sobs, freq. complaints
Consolability	<u>0</u>	0 = Content, relaxed 1 = Reassured by touching, hugging, talking, distractible 2 = Difficult to console or comfort
<u>2</u>		TOTAL SCORE

HOSPICE CARE OF SOUTH CAROLINA

DEATH INFORMATION FOR FUNERAL HOME

Revised 2-14-07

Name: Farr, William Med. Rec.#: 102406

Address: 1032 Jonesville Lockhart Hwy
Union SC 29379

Phone: 864-674-6219

Date of Birth: [REDACTED] Age: 69 Race: Caucasian

Marital Status: (M) S D W Social Security #: [REDACTED]

Date of Death: 6/19/12 Time of Death: 4:15 AM (PM)

*Assessment of Death by C. Lynn Edwards RN
(Hospice Care of South Carolina RN Signature)

Diagnosis Malignant neoplasm of bronchus + Lung

MD to Certify Sharmila Mehta

MD Address: 380 Serpentine Dr Suite 200 Sptb, SC

MD Phone#: 864 560 7050 29307

Transported to: Holcombes F.H. By: [Signature]

Body Released to: Tommy Genoble
(Signature)

Location of Incident: 1032 Jonesville Lockhart Hwy

Next of Kin: Delores Farr Relation: Spouse

Address: 1032 Jonesville Lockhart Hwy Union SC 29379

Phone #: 864-674-6219

(V-51)

STATE OF SOUTH CAROLINA	)	IN THE COURT OF COMMON PLEAS
	)	
COUNTY OF SPARTANBURG	)	7th JUDICIAL CIRCUIT
	)	
Lisa McKaughan, Individually and as the	)	C.A. No.: 2013-CP-42-02404
Personal Representative of the	)	
Estate of William Farr,	)	
	)	
Plaintiff,	)	
	)	
v.	)	MOTION <i>IN LIMINE</i>
	)	OF THE DEFENDANTS
Upstate Lung and Critical Care	)	
Specialists, P.C.; and Sau-Yin Wan, M.D.,	)	
	)	
Defendants.	)	

TO: WILLIAM A. MCKINNON, ESQ., ATTORNEY FOR THE PLAINTIFF:

Defendants Upstate Lung and Critical Care Specialists, P.C. and Sau-Yin Wan, M.D., by and through counsel, hereby submit this Motion *In Limine* pursuant to the South Carolina Rules of Evidence and South Carolina case law to exclude the following matters from the trial of this case:

(1) Any testimony or other evidence that Mr. Farr's lung cancer spread or metastasized through the "endobronchial" or "aerogenic" mechanism, a wholly unsubstantiated theory in medicine which should be excluded under *Daubert* and its South Carolina progeny;

(2) Any testimony or other evidence by an expert witness about whether a fact, opinion, diagnosis, cause or any other matter is "possible," since the law requires that admissible expert testimony shall be offered "to a reasonable degree of medical certainty" and "most probably," not what is merely "possible";

(3) Any testimony or other evidence suggesting that Dr. Wan was grossly negligent, reckless, intentional or acted with a conscious disregard for Mr. Farr, since Plaintiff's experts have unequivocally testified that no such conduct occurred in this case;

(4) Any testimony or evidence suggesting that the Defendants violated "safety rules" under the "Reptile" theory, since such testimony or evidence imposes an improper legal standard into the courts of this State; and

(5) Any evidence of the income of physician Gregory J. Feldman, M.D. produced in discovery only under a strict Confidentiality and Protective Order.

BACKGROUND

This is a medical malpractice case. Trial is set to begin on July 27, 2015 in Spartanburg County. Plaintiff alleges that Dr. Wan deviated from the standard of care by failing to timely diagnose lung cancer on an x-ray of Mr. Farr in January of 2010 which allegedly caused his death in June of 2012. Plaintiff, by and through counsel, filed a Notice of Intent to File Suit alleging medical malpractice on December 12, 2012. After the Notice of Intent process completed and ended in an impasse, Plaintiff filed the Summons and Complaint on June 3, 2013 after which the Defendants timely filed their Answer denying liability.

More specifically, Plaintiff's deceased, Mr. Farr, was referred to pulmonologist Dr. Wan by his hematologist/oncologist Dr. Sarah Vidito on January 5, 2010 to get his lungs checked as a part of her (Dr. Vidito's) continuous treatment for erythrocytosis, a condition of elevated red blood cells resulting from his life-long smoking abuse. Dr. Wan evaluated Mr. Farr on January 11, 2010 at her office, performed a physical exam, ordered and performed a pulmonary function test and a chest x-ray with two views (AP and lateral). She diagnosed Mr. Farr as having mild hypoxemia, dyspnea (respiratory insufficiency) and chronic obstructive pulmonary disease ("COPD") as a result of his life-long smoking abuse. She noted that the x-rays showed "hyperinflation" (due to COPD) and "no infiltrate." She noted that the plan was for "SMOKING CESSATION!" and provided a prescription for Chantix to assist with this plan. She noted that he should return to the clinic in 6 months. Mr. Farr, however, did not follow up with Dr. Wan.

On October 6, 2010, Mr. Farr was seen by his family physician, Dr. Ronald Littlefield, for a routine checkup for "multiple medical problems" with increased shortness of breath and chest pain. Dr. Littlefield ordered a stress test, echocardiogram and a chest x-ray, among other tests for evaluating his complaints. The chest x-ray interpretation on October 7, 2010 by radiologist Dr. Raul Ceballos, Jr. stated "No hilar or mediastinal adenopathy or mass lesions evident...confluent patchy and streaky radiopacities in the anterior segment of the right upper lobe...While this may be chronic in nature, early or evolving pneumonitis cannot be excluded...In addition, the possibility of an underlying occult pulmonary mass cannot be totally excluded." As a result of this x-ray, CT and PET scans were ordered, which did not clearly show cancer and which were ultimately inconclusive. Nonetheless, Mr. Farr sought surgical exploration for possible right lung cancer on December 2, 2010 by oncological surgeon Dr. Christophe Nguyen in Spartanburg.

As noted in the December 2, 2010 operative report of Dr. Nguyen and as a result of the surgical pathology report of pathologist Dr. David Wren, all of Mr. Farr's lung cancer (papillary predominant adenocarcinoma) was removed. The lymph nodes were removed, all of which were negative for lymphatic spread or metastasis. The surgical margins were also clear, evidencing no spread of cancer. The first line of Dr. Nguyen's dictated operative note states "No evidence of metastatic disease."

The surgical pathology slides were reviewed a few months later (as a result Mr. Farr's decision to obtain a second opinion on whether or not to receive adjuvant chemotherapy) in February of 2011 by pathologists Dr. Masha Bilie and Dr. Paul Eberts at the Medical University of South Carolina ("MUSC"). Dr. Bilie and Dr. Eberts concluded the same findings as that of Dr. Wren in Spartanburg: the lymph nodes were negative for cancer, the surgical margins were clear, and the cancer type was "adenocarcinoma, papillary predominant histological subtype." This

MUSC pathology report confirmed Dr. Wren's pathological and Dr. Nguyen's surgical determinations that all of Mr. Farr's lung cancer was removed and that there was no metastasis.

During the next fourteen (14) months, Mr. Farr continued to smoke against medical advice. His oncologist, Dr. Sharmila Mehta, noted in his May 10, 2011 visit, for example, that "Unfortunately, the patient continues to smoke and I have once again expressed to him the greatest factor of his cancer coming back is because he continues to smoke on a regular basis...He continues to refuse formal smoking cessation."

Also, during these fourteen (14) months, he was seen and evaluated periodically by various treating physicians for follow-up care, and eventually there became a clinical suspicion of a possible recurrence, but with respect to Mr. Farr's *left* lung. As a result, surgeon Dr. Nguyen resected a portion of Mr. Farr's left lung on April 17, 2012. The surgical specimens were reviewed by pathologist Dr. Rosanna Lapham, who issued her surgical pathology report on April 20, 2012 and concluded that the left lung was "adenocarcinoma, lipidic predominant and with acinar pattern...within the random sections of the lung parenchyma there are multiple minute foci of lipidic in situ adenocarcinoma." Dr. Lapham testified in her deposition that this left lung cancer was a *new primary cancer and not a metastasis*. This left lung cancer was of a different histological subtype than the right lung cancer, and the left lung cancer had *in situ* components, which reflected that this left lung cancer originated in the left lung (i.e. - did not spread from the right lung). As a result, this left lung cancer was unrelated to Mr. Farr's right lung cancer, which was completely removed about one and a half years earlier.

Mr. Farr died soon thereafter in June of 2012 as a result of his chronic pulmonary issues caused by smoking all of his life (against medical advice), even until the very month of his death, as noted in his medical records.

Plaintiff alleges that Dr. Wan misdiagnosed Mr. Farr's chest x-ray of January 11, 2010 by failing to detect his right lung cancer. Even though the right lung cancer was completely removed surgically and that it did not spread by any of the known mechanisms of metastasis (i.e. - hematogenous metastasis, lymph node metastasis or by direct extension into other tissues) as confirmed by pathologists Dr. Wren, Dr. Eberts, Dr. Bilie, Dr. Lapham and defense expert pathologist Dr. J. Thomas Latham, Plaintiff alleges that the right lung cancer somehow spread through the "endobronchial" or "aerogenic" spread theory, which has not been proven in any way or recognized as an accepted pathological mode of metastasis. Plaintiff's "aerogenic" theory basically suggests that lung cancer can spread by "breathing," which has no proven basis whatsoever in the pathology literature.

Defendants submit this Motion *In Limine*, *inter alia*, to exclude evidence of Plaintiff's unsupported "endobronchial" or "aerogenic" spread theory on the basis that it is not reliable whatsoever under Rule 702, SCRE, *Daubert v. Merrell Dow Pharm.*, 509 U.S. 579 (1993), *Graves v. CAS Med. Sys., Inc.*, 2012 S.C. LEXIS 179, *Watson v. Ford Motor Co.*, 2010 S.C. LEXIS 50, *State v. White*, 382 S.C. 265, 676 S.E.2d 684 (2009), and *State v. Council*, 335 S.C. 1, 515 S.E.2d 508 (1999). Defendants further seek to exclude evidence or testimony as additionally mentioned herein above for the reasons set forth below.

ARGUMENT

I. ANY EVIDENCE OR TESTIMONY OF THE "ENDOBRONCHIAL," "AEROGENIC," OR "BREATHING" THEORY OF CANCER METASTASIS SHOULD BE EXCLUDED AS UNRELIABLE.

Plaintiff's pathology expert, Dr. Willard P. Milby's opinion that Mr. Farr's lung cancer spread and metastasized by *breathing* is unreliable under South Carolina law and is unsupported by any medically proven or evidence-based methodology and would be misleading to a jury. Therefore, it should be excluded from trial.

"The admission of expert testimony is governed by Rule 702 of the South Carolina Rules of Evidence, which provides:

If scientific, technical, or other specialized knowledge will assist the trier of fact to understand the evidence or to determine a fact in issue, a witness qualified as an expert by knowledge, skill, experience, training, or education, may testify thereto in the form of an opinion or otherwise."

Watson, at *7. The South Carolina Supreme Court recently held that:

The trial courts of this state have a gatekeeping role with respect to all evidence sought to be admitted under Rule 702, whether the evidence is scientific or nonscientific. In the discharge of its gatekeeping role, a trial court must assess the threshold foundational requirements of qualifications and reliability and further find that the proposed evidence will assist the trier of fact. The familiar evidentiary mantra that a challenge to evidence goes to 'weight, not admissibility' may be invoked only after the trial court has vetted the matters of qualifications and reliability and admitted the evidence.

White at 274, 676 S.E.2d 684, 689. The "trial court must evaluate the substance of the testimony and determine whether it is reliable." *Watson*, at *9; *Council*, *supra*. Reliability of expert testimony is determined by application of the following factors:

(1) the publication and peer review of the technique; (2) prior application of the method to the type of evidence involved in the case; (3) the quality control procedures used to ensure reliability; and (4) the consistency of the method with recognized scientific laws and procedures.

Watson, at *15. *Council* at 19, 515 S.E.2d 508, 517.

Because Dr. Milby's opinion on causation is not reliable and would be misleading to a jury, his testimony should be excluded from trial.

Specifically, Dr. Milby testified in his deposition that even though there is no evidence showing Mr. Farr's lung cancer metastasized by the three medically-accepted mechanisms (i.e. - through lymphatics, blood or direct extension), Mr. Farr's lung cancer metastasized from his right lung to his left lung through the synonymously termed "endobronchial," "aerogenic" or "breathing" metastasis theory. Dr. Milby testified as follows:

Q. What are the different mechanisms of metastases?

- A. Well, there are several. There is hematogenous, where it's spread through the bloodstream, the lymphatic spread has gone into the lymphatic gland. In certain cases, like in this case, I believe, there's endobronchial spread, or spread through the airways.

(Milby Dep. 22:25-23:8).

Dr. Milby stated that the "endobronchial" or "aerogenic" spread occurs when the person breathes, essentially claiming that cancer spreads the same way as the common cold. He described the mechanism as follows:

- Q. You talked about endobronchial spread or aerogenic spread. Would that be the correct term?
- A. That's correct.
- Q. Describe for me that mechanism. How does that work?
- A. It would be a subset. The individual tumor cells, small clusters of tumor cells would break off. And it's just through the normal process of respiration, breathing in and out, that they're carried to other parts of the lung.

(Milby Dep. 29:1-10).

Dr. Milby agreed that if the cancer spread by the three known ways cancer can spread (i.e. - through lymphatics, blood or direct extension), there should be evidence of such spread (none of which occurred in this case). However, he said that cancer can spread "aerogenically" through the airways *but without any evidence* of it doing so. In this case, that is exactly what Dr. Milby thinks: because there is no evidence of metastasis in any way whatsoever, it must have occurred through breathing because, in his opinion, it is the only mechanism of spread that occurs without any evidence of spreading. Dr. Milby testified as follows:

- Q. In terms of spread, for example, if it's blood borne, typically you're going to have multiple metastases and that could be evidence of a blood-borne metastasis, correct?
- A. Correct.
- Q. And if it's by tumor extension, is that going to occur if it's beyond the surgical markers?
- A. Correct.
- Q. If the margins are positive and it spreads continuously, then that's what you would have, correct?

A. Correct.

Q. And if you had a lymphatic spread, you're probably going to have some kind of evidence of lymphovascular invasion or positive lymph nodes somewhere, correct?

A. Correct.

Q. But in endobronchial spread, you may not have any evidence directly of that kind of spread?

A. True.

(Milby Dep, 30:8-31:2).

Dr. Milby agreed that there is no evidence of any kind of lung cancer spread or metastasis in this case. Therefore, in his opinion, there must have been "aerogenic" spread of cancer, even though there would be no evidence of it. Such an unproven and baseless assertion from a medical standpoint is not reliable, and should not be admitted in court.

As noted above, the reliability of expert testimony is determined by application of the following factors:

(1) the publication and peer review of the technique; (2) prior application of the method to the type of evidence involved in the case; (3) the quality control procedures used to ensure reliability; and (4) the consistency of the method with recognized scientific laws and procedures.

Watson, at *15. *Council* at 19, 515 S.E.2d 508, 517.

Because each of these four factors do not weigh in favor of admissibility with respect to Dr. Milby's opinion on metastasis, this Court should exclude such testimony.

A.) The publication and peer review of the technique.

The first factor to consider when determining reliability under *Council* is the "publication and peer review of the technique." *Id.* If a technique or scientific mechanism had some indicia of reliability, there would surely be some specific pathology literature or peer review publication to support it. In this case, there is no specific evidence-based pathology literature or proven peer review evidence supporting Dr. Milby's opinion that Mr. Farr's lung cancer spread from his right lung to his left lung by the theory of "breathing." Dr. Milby has provided no specific literature

describing evidence-based studies or any other literature proving the viability of his theory in this matter. Dr. Milby should not be able to offer a medically-unproven thought or suggestion on such a critical issue in this case when it is not reliable and when all other pathologists in the case have testified that they have never heard of such a theory.¹ Certainly, this "publication and peer review of the technique" factor is not met by the Plaintiff, and is, therefore, not a basis for admissibility under *Council*.

B.) Prior application of the method to the type of evidence involved in the case.

The second factor to consider when determining reliability under *Council* is the "prior application of the method to the type of evidence involved in the case." *Id.* There is no specific article or other evidence Dr. Milby can reference, in terms of the application of this "breathing" method of lung cancer metastasis, to reliably support his theory of causation. In other words, there is no proven support, either in the pathology literature or by other experts, to form the basis of Dr. Milby's "breathing" theory of metastasis. Has the method or process of "breathing" been tested pathologically to prove that papillary-predominant adenocarcinoma of the right lung can metastasize by "breathing" into lipidic-predominant adenocarcinoma of the left lung? Absolutely not. There are no studies or other proven evidence in the pathology literature describing a method for testing such a theory. It simply has not been tested. There are no pathology studies on this. And there is certainly no proven method by which Dr. Milby can validly base such a theory.

Additionally, and as noted above, two other pathologists involved in this matter - treating pathologist Dr. Rosanna Lapham and defense expert Dr. Thomas Latham, two pathologists who completed post-graduate fellowships in oncological pathology from highly respected cancer

¹ Dr. Rosanna Lapham, treating pathologist, and Dr. Thomas Latham, an expert pathologist for the Defendants, both testified in their recent depositions that they have never heard of such a theory. Their deposition transcripts have not yet been received for purposes of citing them directly on this issue.

centers M.D. Anderson in Texas and Sloan-Kettering Cancer Center in New York, respectively - testified in this very case that they have never heard of Dr. Milby's "breathing" theory nor could they find evidence or studies in the literature supporting such a theory. Clearly, then, there is no valid evidence before this Court supporting the "prior application of the method to the type of evidence involved in the case." This factor certainly weighs against admissibility under *Council*.

Finally, and quite revealing, is Dr. Milby's own admission that unlike the other three known ways cancer can metastasize (i.e. - through lymphatics, blood or direct extension), this "breathing" theory is the only such theory - according to Dr. Milby - by which there would be no evidence to prove it. He testified as follows:

Q. But in endobronchial spread, you may not have any evidence directly of that kind of spread?

A. True.

(Milby Dep. 30:25-31:2).

By his *own* admission, this "breathing" theory is merely that - just a theory, and Dr. Milby cannot support it through any reliable method. Therefore, this factor is not a basis for admitting such causation testimony under *Council*.

C.) The quality control procedures used to ensure reliability.

The third factor to consider when determining reliability under *Council* is the "quality control procedures used to ensure reliability." *Id.* Because there have been no pathology publications, peer review literature or prior applications of any scientific method to specifically test and support (through evidence-based medicine) the "breathing" theory of metastasis, there necessarily follows that no quality control procedures have been used to ensure reliability of such a theory. To the contrary, there is much evidence-based literature and knowledge supporting the fact that cancer can spread through the blood, the lymphatics or direct extension, but there is none

with respect to the “breathing” theory of metastasis. This factor - “the quality control procedures used to ensure reliability” - cannot be met by Plaintiff to support its admissibility, either.

1.) The “aerogenic” theory is not the “best explanation” for metastasis under *Graves v. CAS Medical Systems, Inc.*

The Supreme Court of South Carolina recently decided the *Graves v. CAS Medical Systems, Inc.* case in which the Court excluded the three (3) plaintiff experts’ opinions on the basis that they were unreliable. *Graves v. CAS Medical Systems, Inc.*, 401 S.C. 63, 735 S.E.2d 650 (2012). Specifically, the Court excluded their opinions that a medical device designed to detect and alarm a baby’s slow heart rate and breathing must not have worked properly because the parents did not wake up to hear the alarm, despite that the findings that the machine’s internal recording system appeared to reflect that it did, in fact, work properly. *Id.* Certain theories were advanced by the three experts to suggest that the alarm likely did not sound or work properly, despite the myriad of evidence suggesting that it did work properly and that the parents likely slept through the alarm. *Id.* The Supreme Court of South Carolina explained that the “differential diagnosis” or “best inference” test is a proper test for applying an analysis under this third prong of the *Council* factors, namely the “quality control procedures to ensure reliability.” *Id.* at 75-78, 735 S.E.2d 650, 656-57.

The Court stated that “Although this is our first opportunity to assess the reliability of an opinion rendered using the reasoning to the best inference methodology, other courts have already done so. In *Westberry v. Gislaved Gummi AB*, 178 F.3d 257 (4th Cir. 1999), the court described the differential diagnosis methodology as a process of identifying a cause by ‘eliminating the likely causes until the most probable one is isolated.’ *Id.* at 262.” *Id.* The Court further stated that “While the strength of an expert’s rejection of possible alternative causes usually is an issue for the jury, when an expert cannot offer an explanation for the rejection of a possible alternative

cause, the expert's testimony is not sufficiently reliable. *Id.* at 265. Accordingly, we hold an expert relying on differential diagnosis must provide a reasonable, objective explanation for the rejection of possible alternative causes in order for the opinion to be admissible under Rule 702. We believe this objectivity requirement is consistent with the quality control element of *Council*.
Id.

In the instant case, Dr. Milby cannot offer an "objective explanation for the rejection of possible alternative causes" for the fact that there was no evidence of cancer metastasis from the right lung to the left lung. As known by essentially all physicians who diagnose or treat cancer, including Dr. Milby himself, cancer metastasizes by one of three pathways: (1) lymphatic spread, (2) hematogenous (blood-borne) spread, or (3) direct extension into other tissues or surrounding structures.² If there is metastasis, there would be evidence of the process of metastasis. For example, if by lymphatic spread, there would be a positive lymph node. If by hematogenous spread, there would be evidence of distant metastases. If by direct extension, there would be surgical resection margins that were unclear and showed tumor extension into other tissues or surrounding structures. The evidence shows that none of these occurred in this case – objectively. Dr. Milby has no objective evidence to show that cancer spread through the airways in Mr. Farr by "breathing." *The only evidence regarding metastasis whatsoever is the objective evidence showing cancer did not spread by the three known and accepted ways it can spread. There is no objective evidence that cancer spread through the airways by "breathing," and such a theory is not even an accepted mode of metastasis anyway.* And, significantly, the cancer diagnosed in the left lung was a totally different cancer than the cancer diagnosed in the right lung.³

² Dr. Milby himself cited a textbook about the ways cancer can spread – ROBBINS AND COTRAN, PATHOLOGIC BASIS OF DISEASE 273 (9th ed.) – which states that "Dissemination of cancers may occur through one of three pathways: (1) direct seeding of body cavities or surfaces, (2) lymphatic spread, and (3) hematogenous spread."

³ See pathology reports dated December 6, 2010 and April 17, 2012 and depositions of Dr. Lapham and Dr. Latham.

Dr. Milby cannot pass the objectivity test required under *Graves*. He has no evidence whatsoever to show the cancer spread by “breathing,” and the objective evidence rules out metastasis in all three of the ways by which cancer is known to spread. Therefore, this factor - “the quality control procedures used to ensure reliability” - cannot be met by Plaintiff to support the admissibility of Dr. Milby’s opinion, either.

D.) The consistency of the method with recognized scientific laws and procedures.

The fourth factor to consider when determining reliability under *Council* is the “consistency of the method with recognized scientific laws and procedures.” *Id.* Because there have been no reliable methods - *at all* - to test or pathologically determine the “breathing” theory of the spread of cancer, there have been no consistent methods, scientific laws or procedures diagnostic of such a theory. Therefore, it necessarily follows that this *Council* factor has not been satisfied for purposes of providing a basis for the reliability of Dr. Milby’s “breathing” theory of metastasis.

In sum, Dr. Milby’s opinion on causation is not reliable and his testimony should be excluded from trial. Dr. Milby’s theory that Mr. Farr’s right lung cancer metastasized to his left lung by “breathing” is not supported by *any* reliability factor under *Council*. When weighing these factors, this Court should recognize that Dr. Milby’s theory is unsupported in medicine and should not be offered as evidence in the trial of this case. It is not reliable, and the Court’s duty to protect a jury from considering unreliable information and misleading testimony should be exercised in this particular case. The Court, as the gatekeeper of evidence under Rule 702, SCRE, should find that not only will the proposed testimony that cancer can spread by “breathing” fail to assist the jury, it would confuse and actually mislead the jury under Rule 403, SCRE. This theory is simply and clearly unreliable, and it should be excluded from the trial of this case.

II. EXPERT TESTIMONY ABOUT WHAT IS "POSSIBLE" SHOULD BE EXCLUDED SINCE THE LAW REQUIRES THAT EXPERT OPINIONS BE GIVEN "TO A REASONABLE DEGREE OF MEDICAL CERTAINTY" AND "MOST PROBABLY."

This Court should exclude any testimony or other evidence by any expert witness about whether a fact, opinion, diagnosis, cause or any other matter is "possible," since the law requires that admissible expert testimony shall be given "to a reasonable degree of medical certainty" and "most probably," not what is merely "possible." *Green v. Lilliewood*, 272 S.C. 186, 249 S.E.2d 910 (1978); *Payton v. Kearse*, 329 S.C. 51, 495 S.E.2d 205 (1998); *Gooding v. St. Francis Xavier Hosp.*, 326 S.C. 248, 487 S.E.2d 596 (1997); *Taylor v. Medenica*, 324 S.C. 200, 479 S.E.2d 35 (1996); *Brown v. Carolina Emergency Physicians*, 348 S.C. 569, 560 S.E.2d 624 (Ct. App. 2001).

III. TESTIMONY OR EVIDENCE SUGGESTING THAT DR. WAN WAS GROSSLY NEGLIGENT, RECKLESS OR ACTED WITH A CONSCIOUS DISREGARD SHOULD BE EXCLUDED.

This Court should exclude any testimony or other evidence suggesting that Dr. Wan was grossly negligent, reckless, or acted with a conscious disregard for Mr. Farr, since Plaintiff's experts have unequivocally testified that none occurred in this case. Plaintiff's expert radiologist, Dr. William Woodruff, testified in his deposition as follows:

- Q. Now, in terms of your opinions and what you just stated in terms of the misinterpretation of these X-rays by Dr. Wan, are you going to offer an opinion that she misinterpreted them with a conscious disregard for this patient?
- A. Well, I cannot say that. I don't know Dr. Wan. I wasn't there at the time. I don't think that's -- no, I do not believe.
- Q. Are you going to say that Dr. Wan was grossly negligent in this case?
- A. I'm not sure I understand what that means.
- Q. If the definition is it means that is was intentional or Dr. Wan acted with a conscious disregard and reckless, if that was the gist of the definition of gross negligence, would you say that Dr. Wan was grossly negligent?
- A. No, sir, I don't think I can say that. I don't believe I would say that.

(Woodruff Dep. 56:14-57:8).

Plaintiff's expert oncologist, Dr. Barry Singer, testified that he is not offering standard of care opinions and that he is strictly offering causation opinions. He testified as follows:

- Q. My question is are you planning to offer standard of care opinions like Dr. Woodruff did or are you offering causation opinions in this case?
- A. Strictly causation. I did read Dr. Woodruff's deposition, I did look at the x-rays, I am an internist, I look at chest x-rays all the time but I'm strictly not giving standard of care.

(Singer Dep. 20:8-14).

Plaintiff's expert pathologist, Dr. Milby, likewise testified in his deposition that he is not offering standard of care opinions. He testified as follows:

- Q. Are you offering any opinions critical of Dr. Wan on the standard of care?
- A. No.
- Q. Are you offering any standard of care opinions at all in this case, critical of the care?
- A. No.

(Milby Dep. 61:24-62:4).

Since two of the three experts for the Plaintiff are not offering opinions on the standard of care or opinions critical of Dr. Wan, and because Plaintiff's only standard of care witness, Dr. Woodruff, has testified that he will not be offering opinions that Dr. Wan was grossly negligent, reckless, or acted with a conscious disregard in this matter, this Court should exclude any such testimony, evidence, or statements and arguments from counsel for the Plaintiff in this matter.

IV. TESTIMONY, EVIDENCE, QUESTIONS OR ARGUMENTS ADVANCING THE PLAINTIFF'S "REPTILE THEORY" SHOULD BE EXCLUDED FROM TRIAL.

Any testimony, evidence, questions or arguments offered for the purpose of advancing the Plaintiff's "Reptile" theory, use of "safety rules," or heightened duty of care (*See, e.g., Sulton v. Healthsouth Corp.*, 400 S.C. 412, 734 S.E.2d 641 (2012)) is improper and should be excluded from the trial of this case.

The "Reptile" approach is designed to make the jury feel that a defendant has threatened their safety and the safety of the community at large, therefore compelling the jury to protect themselves and the community by rendering a verdict for a plaintiff. Its primary goal is to show the immediate danger of the kind of thing a defendant did and how "fair" compensation can diminish that danger in the community. The "Reptile" theory is intended to cause jurors to act out of fear and in pursuit of survival instead of making a rational determination of the facts and evidence of a particular case. It ignores what cannot be prevented, such as accidents, mistakes, and misjudgments, and implies that accidents happen when a defendant violates a "safety rule." The "Reptile" theory preaches that a proper (large) verdict for a plaintiff will reduce the danger a defendant's actions pose to the community and provides that without a proper verdict, the danger will increase. Therefore, the "Reptile" approach is improper and should be excluded from the trial of this case for the following reasons:

A.) Violation of the Golden Rule.

The Reptile approach is designed to make the jury feel that the defendant has threatened the safety of the jury and their community by allegedly operating in a manner that places them in danger. The purpose of this approach is to have the jury decide the case based upon the fear that they or another member of their family or community could have been injured by the actions of the defendant. As such, these types of questions are a direct violation of the Golden Rule which prohibits either party from asking the jury to place themselves into the place of either party. *See State v. Reese*, 359 S.C. 260, 271, 597 S.E.2d 169, 175 (Ct. App. 2004) (recognizing that a "Golden Rule" argument which suggests to jurors to put themselves in the shoes of one of the parties is generally impermissible because it encourages the jurors to depart from neutrality and to decide the case on the basis of personal interest and bias rather than evidence), *aff'd in part and rev'd in part*, 370 S.C. 31, 633 S.E.2d 898 (2006); *see also Von Dohlen v. State*, 360 S.C. 598, 611, 602

S.E.2d 738, 745 (2004) (noting that South Carolina and other courts have uniformly “condemned and prohibited golden rule arguments in criminal and civil setting”); *Myrick v. Stephanos*, 220 Ga. App. 520, 522, 472, S.E.2d 431, 435 (1996) (reversing \$1.9 million judgment against motor carrier and driver on grounds that trial court improperly failed to exclude plaintiff’s counsel’s “Golden Rule” argument during his closing argument).

B.) Speculative damages and damages to others beyond the plaintiff.

The Reptile approach is designed to convince the jury to award damages for speculative damages for harm that might have occurred, or potential harm to the plaintiff’s family or general community, instead of actual damages in the case. This violates South Carolina law prohibiting speculative damages and damages to others than the plaintiff in the case. *See, e.g., Whisenant v. James Island Corp.*, 277 S.C. 10, 13, 281 S.E.2d 794, 796 (1981) (noting that recoverable damages require evidence that allows the jury to determine the amount with reasonable certainty or accuracy, and damages may not be left to conjecture, guess or speculation).

C.) Verdict based on emotion or passion.

The Reptile approach attempts to convince a jury to decide the case based upon emotion and passion, suggesting an improper basis for making a decision under Rule 403, SCRE. As such, the Reptile approach violates South Carolina law. *See, e.g., State v. Collins*, 398 S.C. 197, 207-8, 727 S.E.2d 751, 757 (Ct. App. 2012) (discussing Rule 403 at length, and noting that “unfair prejudice . . . speaks to the capacity of some concededly relevant evidence to lure the factfinder into declaring guilt on a ground different from proof specific to the offense charged”).

D.) Reptile approach falsely implies intent rather than negligence.

The Reptile line of questioning improperly insinuates that a defendant has acted with malicious intent in their actions when such actions are simple negligence. It is improper to attempt to improperly create an impression of evil intent where none exists. The Reptile approach

advocates sending a message to the defendants or asks the jury to serve as the conscience of the community, which is not proper in a negligence case.

E.) Verdict based on "safety" and "danger" instead of the standard of care.

The Reptile approach uses terms such as "safety," "safety rules," "danger," and "choices" to create an impression with the jury that a defendant wrongfully acted in an unsafe manner or a manner which endangered the plaintiff. This is a medical malpractice action where the issue is whether the Defendants violated the standard of care in their provision of treatment to Mr. Farr. There are no recognized "safety rules" that govern the practice of medicine, much less the issues in this case. Further, there is no evidence (or even an allegation) the Defendants endeavored to "endanger" Mr. Farr. Allowing questions by Plaintiff's counsel that insinuate patient endangerment would be grossly inappropriate. The standard of care governs the Defendants' conduct. *See, e.g., Pederson v. Gould*, 288 S.C. 141, 341 S.E.2d 633 (1986). The standard of care refers to what a reasonable medical provider would have done under the same or similar circumstances as the defendant. The standard of care does not incorporate non-existent "safety rules." Allowing the jury to entertain references to "safety rules" and "danger" risks improperly influencing it to render a verdict out of fear and emotion, as opposed to a rational analysis of whether a defendant acted within the standard of care.

F.) Potential harm versus actual harm.

The Reptile approach attempts to have a jury decide a case and award damages based on what might have occurred, or the potential harm to the community through a defendant's actions. It is improper to attempt to convince the jury to award damages based upon potential damages or on what might have occurred. Any arguments should properly be limited to the actual events of the particular case.

G.) Deprivation of a defendant's right to a fair trial.

A defendant is constitutionally entitled to an impartial jury. The Reptile approach is an attempt to violate a defendant's constitutional rights. South Carolina law disallows any argument that asks jurors to put themselves in the shoes of a party or which arouses their passion or prejudice. Such arguments destroy the impartiality of the jurors and encourage them to depart from neutrality and decide a case based upon personal interest and bias rather than on the evidence. This violates a defendant's right to a fair trial by an impartial jury and should not be attempted or permitted.

V. DR. FELDMAN'S INCOME OR QUESTIONS CONCERNING HIS INCOME SHOULD NOT BE ADMISSIBLE UNDER RULES 402 AND 403 OF THE SOUTH CAROLINA RULES OF EVIDENCE.

This Court should exclude evidence of Dr. Greg Feldman's income or any questions related thereto as such personal information is irrelevant under Rule 402, SCRE and unduly prejudicial under Rule 403, SCRE. Dr. Feldman's income was produced in discovery only under a strict Confidentiality and Protective Order. He was named as an expert witness because he was the managing physician at Upstate Lung and Critical Care, P.C. who knew about the claim because his employed physician, Dr. Wan, was being sued. He was deposed by Plaintiff's counsel and was asked in his deposition to produce his income for purposes of showing bias. The undersigned counsel for the Defendants properly objected to its production, and a motion was filed. A hearing subsequently took place, and, after the judge ordered it to be admitted for discovery purposes, it was disclosed only under a filed Consent Confidentiality and Protective Order. Though it may have been produced in discovery, it certainly should not be admissible at trial.

Plaintiff's counsel intends to question Dr. Feldman about his specific income not merely to show bias, but to show the amount of money Dr. Feldman makes as a physician to insinuate that he and the practice have money for purposes of encouraging a jury to justify rendering a verdict for the Plaintiff. This purpose strikes to very core of why Plaintiff's counsel requested the specific

income Dr. Feldman earned in the year 2014, instead of simply arguing that Dr. Feldman is allegedly biased based on his affiliation as a partner of the practice. While bias under Rule 608(c), SCRE may be inquired into on cross examination, Rule 403, SCRE prevents unduly prejudicial information from being admitted at trial. Dr. Feldman's specific income is also not relevant to the issues and facts of this case under Rule 402, SCRE.

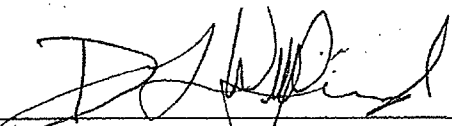
In this specific instance, Plaintiff's counsel may point out that Dr. Feldman is one of the physician owners at Upstate Lung and Critical Care, P.C. in an attempt to show bias, but asking about specific dollars and cents of Dr. Feldman's income is highly prejudicial and serves a purpose other than trying to show bias and affiliation – and such a maneuver is intended to inflame the jury and contribute to a verdict based on what income Dr. Feldman makes instead of the issues and facts of this case. In addition, a filed Consent Confidentiality and Protective Order is in place to protect this information.

Because the specific amounts of Dr. Feldman's income should not be admitted into the trial of this case pursuant to Rules 402 and 403 of the South Carolina Rules of Evidence, this Court should not allow it into the trial, nor allow Plaintiff's counsel to mention it in their opening statement or closing arguments.

CONCLUSION

For the reasons set forth herein above; this Court should exclude the above matters from the trial of this case.

Respectfully submitted,



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July 21, 2015
Greenville, South Carolina

THE STATE OF SOUTH CAROLINA
In the Court of Appeals

APPEAL FROM SPARTANBURG COUNTY
Court of Common Pleas

J. Mark Hayes, II, Circuit Court Judge

Case No. 2013-CP-42-2404
Appellate Case No. 2015-001828

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SC Court of Appeals

Lisa McKaughan, Individually
and as Personal Representative
of the Estate of William Farr,

..... Appellant

v.

Upstate Lung and Critical Care
Specialists, P.C. and Sau-Yin
Wan, M.D.

..... Respondents.

CERTIFICATE OF COUNSEL

Pursuant to Rule 210(g), SCACR, Appellant's counsel certifies that the Record on Appeal contains all materials proposed to be included by the parties and not any other material


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Attorneys for Appellant

Rock Hill, SC
April 8, 2016

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MAR 24 2016

CERTIFICATE OF SERVICE BY MAIL

SC Court of Appeals

I, Kennardy Jones, employee of McGowan, Hood & Felder, LLC, attorney(s) for the Plaintiff, do hereby certify that I have served copy(s) of the **Appellant's Record on Appeal**, on the parties listed below by depositing them in the United States Postal Service, with proper postage affixed thereto, on this 22nd day of March, 2016, addressed to the attorney(s) listed below:

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