• [DISCONTINUED] polyvinyl alcohol-povidone (HYPOTEARS) 1.4-0.6 % ophthalmic solution	1-2 drops as needed.
• [DISCONTINUED] zolpidem (AMBIEN) 5 MG tablet	5 mg by PEG Tube route 2 (two) times daily. For paradoxical effect

Allergies

Allergen	Reactions

- Aspirin
- Clemastine
- Menthol
- Nsaids
- Pseudoephedrine
- Tripelennamine
- Triprolidine
- Vancomycin

Current Facility-Administered Medications

Medication	Dose	Route	Frequency	Provider	Last Rate	Last Dose
• 0.9% NaCl infusion		Intravenous	PRN	Thathagari, Neeraja, MD		
• 0.9% NaCl infusion		Intravenous	PRN	Thathagari, Neeraja, MD		
• acetaminophen (TYLENOL) tablet 650 mg	650 mg	Oral	Q4H PRN	Thathagari, Neeraja, MD		650 mg at 01/01/17 0237
• albuterol (PROVENTIL) nebulizer solution 2.5 mg	2.5 mg	Nebulization	Q6H WA	Thathagari, Neeraja, MD		2.5 mg at 01/04/17 1508
• balsam peru-castor oil (VENELEX) ointment		Topical	BID	Thathagari, Neeraja, MD		
• clonazePAM (KlonoPIN) tablet 1 mg	1 mg	Oral	BID	Thathagari, Neeraja, MD		1 mg at 01/04/17 0536
• collagenase (SANTYL) ointment		Topical	Q24H	Gowda, Murliya D, MD		
• furosemide (LASIX) injection 40 mg	40 mg	Intravenous	Daily	Thathagari, Neeraja, MD		40 mg at 01/04/17 1047
• gabapentin (NEURONTIN) 250 mg/5mL oral solution 200 mg	200 mg	Oral	Q8H SCH	Thathagari, Neeraja, MD		200 mg at 01/04/17 1519

Consults - All Notes (continued)

Consults by Kelly, Jessica, PA at 1/4/2017 3:29 PM (continued) Version 1 of 2

• hydrALAZINE (APRESOLINE) injection 10 mg	10 mg	Intravenous	Q6H PRN	Thathagari, Neeraja, MD	10 mg at 12/25/16 1155
• magnesium oxide (MAG-OX) tablet 400 mg	400 mg	Oral	Daily	Thathagari, Neeraja, MD	400 mg at 01/04/17 1047
• morphine 10 MG/5ML oral solution 5 mg	5 mg	Per G Tube	Q3H PRN	Wheeler, Mary Sue, NP	
• morphine injection 2 mg	2 mg	Intravenous	Q3H PRN	Wheeler, Mary Sue, NP	2 mg at 12/29/16 0548
• nystatin (NYSTOP) powder 1 application	1 application	Topical	BID	Thathagari, Neeraja, MD	1 application at 01/04/17 1200
• prednisoLONE acetate (PRED FORTE) 1 % ophthalmic suspension 1 drop	1 drop	Right Eye	Daily	Thathagari, Neeraja, MD	1 drop at 01/04/17 1047
• sennosides (SENOKOT) syrup 8.8 mg	8.8 mg	Per G Tube	BID PRN	Sankaran, Kumaresan, MD	8.8 mg at 01/01/17 0940
• sodium bicarbonate tablet 650 mg	650 mg	Oral	BID	Kolachana, Padmaja, MD	650 mg at 01/04/17 1047
• timolol (TIMOPTIC) 0.5 % ophthalmic solution 1 drop	1 drop	Right Eye	Q12H SCH	Thathagari, Neeraja, MD	1 drop at 01/04/17 1047
• vitamin D 1,000 Units	1,000 Units	Oral	Q12H	Thathagari, Neeraja, MD	1,000 Units at 01/04/17 0536
• zolpidem (AMBIEN) tablet 5 mg	5 mg	Oral	BID	Thathagari, Neeraja, MD	5 mg at 01/04/17 1235

Social History

Substance Use Topics

- Smoking status: Never Smoker
- Smokeless tobacco: Not on file
- Alcohol Use: No

Family History: History reviewed. No pertinent family history.

Review of Systems

Unable to obtain ROS due to patient's mental status and aphasia

Objective:

BP 122/58 mmHg | Pulse 103 | Temp(Src) 98.4 °F (36.9 °C) (Oral) | Resp 20 | Ht 1.575 m (5' 2.01") | Wt 52.164 kg (115 lb) | BMI 21.03 kg/m2 | SpO2 98%

General Appearance: Awake, aphasic, contratcures of upper and lower extremities

Neck: Supple, symmetrical, trachea midline; difficult to assess JVD
RIJ hohn catheter placement

Lungs: Scattered rhonchi and upper airway sounds
Chest wall: No tenderness or deformity
Heart: Regular rate and rhythm, S1 and S2 normal, no murmur, no rub or gallop
Abdomen: Soft, non-tender, non-distended
Extremities: Extremities warm, contracted, no edema
Pulses: 2+ and symmetric all extremities, including radial and DP
Skin: Skin color, texture, turgor normal, no rashes or lesions
Neurologic: Aphasic

Cardiac Data Review

Echo Results

Procedure	Component	Value	Units	Date/Time
Echocardiogram Adlt Ltd W Clr & Dopp Ltd [357850030]				Collected: 12/22/16 0000 Updated: 12/22/16 1347

Narrative:

Inova Heart

,

Transthoracic Echocardiogram
2D, M-mode, Doppler, and Color Doppler
Study date: 22-Dec-2016

Patient: ANASTASIA V ADAMS
MR #: 03999040
Account #: 13063805732
DOB: 11-Jun-1957

Age: 59 years
Gender: Female
Height: 62 in
Weight: 120 lb
BSA: 1.54 mï¾²
BP: 149/ 67

Allergies: ASPIRIN, NSAIDS, CLEMASTINE, MENTHOL, PSEUDOEPHEDRINE, TRIPELENNAMINE, TRIPROLIDINE, VANCOMYCIN

Sonographer: Gregg Simmons, RDCS
Cardiologist: Jennifer Shea, MD

CLINICAL QUESTION: Limited for pericardial effusion

HISTORY: PRIOR HISTORY: pericardial effusion

PROCEDURE: The procedure was performed at the bedside. This was a routine study. The transthoracic approach was used. The study included limited 2D imaging, M-mode, limited spectral Doppler, and color Doppler. Image quality was adequate.

LEFT VENTRICLE: Size was normal. Systolic function was normal. Ejection fraction was estimated to be 65 %. There were no regional wall motion abnormalities. Wall thickness was normal.

AORTIC VALVE: The valve was trileaflet. Leaflets exhibited normal thickness and normal cuspal separation. Doppler: Transaortic velocity was within the normal range. There was no stenosis. There was no regurgitation.

AORTA: The root exhibited normal size.

MITRAL VALVE: Valve structure was normal. There was normal leaflet separation. Doppler: The transmitral velocity was within the normal range. There was no evidence for stenosis. There was trivial regurgitation.

LEFT ATRIUM: Size was normal.

RIGHT VENTRICLE: The size was normal. Systolic function was normal. Wall thickness was normal.

PULMONIC VALVE: Leaflets exhibited normal thickness, no calcification, and normal cuspal separation. Doppler: The transpulmonic velocity was within the normal range. There was no regurgitation.

PULMONARY ARTERY: The size was normal. Doppler: Systolic pressure was within the normal range.

TRICUSPID VALVE: The valve structure was normal. There was normal leaflet separation. Doppler: The transtricuspid velocity was within the normal range. There was no evidence for tricuspid stenosis. There was trivial regurgitation.

RIGHT ATRIUM: Size was normal.

SYSTEMIC VEINS: IVC: The inferior vena cava was normal in size.

PERICARDIUM: A large pericardial effusion was identified circumferential to the heart. There was significant variation in the mitral inflow, however no other evidence of hemodynamic compromise is noted.

IMPRESSIONS:
Normal left and right ventricular chamber size and function. Large circumferential pericardial effusion measuring 18mm anteriorly, 18mm posteriorly and 21mm at the apex. Hemodynamics appear unchanged from yesterday. Compared to prior echocardiogram dated 12-21-2016 no significant change was noted.

SUMMARY:

- Left ventricle:
- Size was normal.
- Systolic function was normal. Ejection fraction was estimated to be 65 %.

- Mitral valve:
- There was trivial regurgitation.

- Right ventricle:
- The size was normal.
- Systolic function was normal.

- Tricuspid valve:
- There was trivial regurgitation.

- Pericardium:
- A large pericardial effusion was identified circumferential to the heart.
There was significant variation in the mitral inflow, however no other evidence of hemodynamic compromise is noted.

Prepared and signed by

Jennifer Shea, MD
Signed 22-Dec-2016 13:47:50

Echocardiogram Adult Complete W Clr/ Dopp Waveform [357850019] Collected: 12/21/16 0000

Updated: 12/21/16 1543

Procedure	Component	Value	Units	Date/Time

Narrative:

Inova Heart

,

Transthoracic Echocardiogram
2D, M-mode, Doppler, and Color Doppler
Study date: 21-Dec-2016

Patient: ANASTASIA V ADAMS
MR #: 03999040
Account #: 13063805732
DOB: 11-Jun-1957
Age: 59 years
Gender: Female
Height: 62 in
Weight: 119.7 lb
BSA: 1.54 mï¾²
BP: 136/ 75

Allergies: ASPIRIN, NSAIDS, CLEMASTINE, MENTHOL, PSEUDOEPHEDRINE, TRIPELENNAMINE, TRIPROLIDINE, VANCOMYCIN

Sonographer: Anthony Tapa, RDCS
Cardiologist: Pamela Sears-Rogan, MD

CLINICAL QUESTION: r/o Valve Disease/Endocarditis

HISTORY: PRIOR HISTORY: Bronchiectasis, GERD, Dysphagia, Anemia, Anoxic Brain Injury

PROCEDURE: The procedure was performed at the bedside. This was a stat study. The transthoracic approach was used. The study included complete 2D imaging, M-mode, complete spectral Doppler, and color Doppler. Image quality was adequate.

SYSTEM MEASUREMENT TABLES

2D mode
AoR Diam (2D): 30 mm
Asc Aorta Diam (2D): 25 mm
IVC: 18.9 mm
LA Dimension (2D): 29 mm
LA ESV: 41600 mm3
LA/Ao (2D): 1
LASV: 27 ml/m2
EF Teichholz (2D mode): 70.3 %
FS (2D-Teich): 39 %
IVSd (2D): 10.3 mm

Consults - All Notes (continued)

Consults by Kelly, Jessica, PA at 1/4/2017 3:29 PM (continued) Version 1 of 2

Procedure	Component	Value	Units	Date/Time

IVSd (2D): 10.3 mm
LVEF Biplane (2D): 67.4 %
LVIDd (2D): 36.2 mm
LVIDs (2D): 22.1 mm
LVOT diam (2D mode): 284 mmï¾²
LVPWd (2D): 10 mm

Apical four chamber
LA ESV Index (A4C): 25.6 ml/m2
LV Area Systolic (A4C): 1180 mmï¾²
LV ESV (A4C): 18200 mm3
LV Length Systolic (A4C): 62.9 mm

Apical two chamber
LA ESV Index (A2C): 26.8 ml/m2

M mode
AV Cusp Sep(MM): 19 mm
TAPSE: 23 mm

Unspecified Scan Mode
AVA (VTI): 277 mmï¾²
AVA (Vmax): 278 mmï¾²
HR; Recent value: 93 HB/min
Mean Gradient: 4 mm[Hg]
Mean Velocity: 999 mm/s
Vmax: 1340 mm/s
CO (LVOT): 100002 mm3/s
LVOT Diameter: 19 mm
LVOT Peak Gradient: 7 mm[Hg]
LVOT Peak Velocity: 1310 mm/s
LVOT VTI: 226 mm
Acceleration Time: 103 ms
Vmax: 970 mm/s
RVSP: 35 mm[Hg]
Mean PG: 30 mm[Hg]
Regurgitation Vmax: 2770 mm/s

LEFT VENTRICLE: Slight flattening of the interventricular septum most consistent with an elevation in right heart pressures. The E to e' ratio of 7 would not suggest an elevation in LA pressure. The cavity was small. Systolic function was normal by Teichholz. Ejection fraction was estimated to be 70 %. There were no regional wall motion abnormalities. Wall thickness was normal. Doppler: Suboptimal assessment of left ventricular diastolic function due in part to the heart rate.

AORTIC VALVE: The valve was probably trileaflet. Leaflets exhibited normal thickness, no calcification, normal cuspal separation, and good mobility.

Doppler: There was no stenosis. There was no significant regurgitation.

AORTA: The root exhibited normal size. The ascending aorta was normal in size.

MITRAL VALVE: Normal mitral valve leaflets with intact leaflet excursion . There is a greater than 25% variation, actual variation was 41%, in the height of the mitral inflow E wave with respiration which could suggest hemodynamic compromise from the pericardial effusion . Clinical correlation is advised.

LEFT ATRIUM: Size was normal.

PULMONARY VEINS: The left and right pulmonary veins connect with the LA.

RIGHT VENTRICLE: The RV appears small and underfilled on the parasternal short axis view. Consider the volume status of the patient. TAPSE is 2.0- 2.3 cm and the RV S' reversal is 14-16 cm/sec both are most consistent with normal RV contractility. The ventricle was small. Systolic function was normal. Wall thickness was normal.

PULMONIC VALVE: Normal pulmonary valve leaflets with intact leaflet excursion . Doppler: There was no significant regurgitation.

PULMONARY ARTERY: The size was normal.

TRICUSPID VALVE: Grossly normal tricuspid valve leaflets with intact leaflet excursion . Trace tricuspid regurgitation with a peak velocity jet of 3.0-3.2 m/sec most consistent with mild to moderate pulmonary hypertension and a PA systolic pressure of 46-51 mmHg if the RA pressure is 10 mmHg.

RIGHT ATRIUM: Dilated coronary sinus which may also be present in the setting of an increase in right heart pressures. Right atrial inversion was not identified. Size was normal.

SYSTEMIC VEINS: IVC: The inferior vena cava was normal in size. Respirophasic changes were blunted (less than 50% variation).

PERICARDIUM: There is a large 1.7-2.0 cm posterior and small 0.9 cm anterior , and 1.8-2.0 cm anterior to the right ventricle,echo free space most consistent with a pericardial effusion . That the RV is small and there is significant variation in the E velocity of mitral inflow, suggest early hemodynamic compromise from the pericardial effusion . Dr. Neeraga Thathagari 703 961 1119 was notified about the findings of the pericardial effusion and potentially underfilled right ventricle prior to the conclusion of this reading.

SUMMARY:

- Left ventricle:
- Slight flattening of the interventricular septum most consistent with an

Procedure	Component	Value	Units	Date/Time

elevation in right heart pressures.
- The E to e' ratio of 7 would not suggest an elevation in LA pressure.
- The cavity was small.
- Systolic function was normal by Teichholz. Ejection fraction was estimated to be 70 %.
- There were no regional wall motion abnormalities.
- Wall thickness was normal.
- Suboptimal assessment of left ventricular diastolic function due in part to the heart rate.

- Mitral valve:
- Normal mitral valve leaflets with intact leaflet excursion .
- There is a greater than 25% variation, actual variation was 41%, in the height of the mitral inflow E wave with respiration which could suggest hemodynamic compromise from the pericardial effusion . Clinical correlation is advised.

- Tricuspid valve:
- Grossly normal tricuspid valve leaflets with intact leaflet excursion .
Trace tricuspid regurgitation with a peak velocity jet of 3.0-3.2 m/sec most consistent with mild to moderate pulmonary hypertension and a PA systolic pressure of 46-51 mmHg if the RA pressure is 10 mmHg.

- Pericardium:
- There is a large 1.7-2.0 cm posterior and small 0.9 cm anterior , and 1.8-2.0 cm anterior to the right ventricle,echo free space most consistent with a pericardial effusion . That the RV is small and there is significant variation in the E velocity of mitral inflow, suggest early hemodynamic compromise from the pericardial effusion . Dr. Neeraga Thathagari 703 961 1119 was notified about the findings of the pericardial effusion and potentially underfilled right ventricle prior to the conclusion of this reading.

COMPARISONS:
No previous echo is available for comparison .

Prepared and signed by

Pamela Sears-Rogan, MD
Signed 21-Dec-2016 15:43:32

EKG Results

Procedure	Component	Value	Units	Date/Time
CARDIAC STRIPS [355045558]				Resulted: 01/04/17 0748 Updated: 01/04/17 0748

Consults by Kelly, Jessica, PA at 1/4/2017 3:29 PM (continued) Version 1 of 2

Labs:

Lab Results

Component	Value	Date
WBC	5.27	01/03/2017
HGB	8.8*	01/03/2017
HCT	27.2*	01/03/2017
MCV	95.1	01/03/2017
PLT	243	01/03/2017

No results found for: CKTOTAL, CKMB, CKMBINDEX
No results found for: CKTOTAL

Lab Results

Component	Value	Date
BUN	27.0*	01/03/2017
NA	132*	01/03/2017
K	4.6	01/03/2017
CL	103	01/03/2017
CO2	25	01/03/2017

Chest X-Ray:

Radiology Results (24 Hour)

**** No results found for the last 24 hours. ****

Consults by Suarez, Brandi, RD at 1/5/2017 5:18 PM Version 2 of 2

Author: Suarez, Brandi, RD | Service: Nutrition | Author Type: Registered Dietitian
Filed: 1/5/2017 5:18 PM | Note Time: 1/5/2017 5:18 PM | Status: Addendum
Editor: Suarez, Brandi, RD (Registered Dieti ian)
Related Notes: Original Note by Suarez, Brandi, RD (Registered Dietitian) filed at 1/5/2017 3:23 PM
Consult Orders:
1. Inpatient consult to Nutrition [360409867] ordered by Thathagari, Neeraja, MD at 01/04/17 1802

Nutrition:

TFs:
Trial of switch to TwoCal formula to decrease duration of time attached to feeding pump (order placed, discussed with Dr Thathagari):
TwoCal @ 55ml/hr x16hrs with flushes 140ml Q3 (will provide 1760 kcals, 74 gm protein, 615mls free water in TF, total 1735mls free water)
Will f/u with RN and patient tomorrow for tolerance

Update:

Consults - All Notes (continued)

Consults by Suarez, Brandi, RD at 1/5/2017 5:18 PM (continued) Version 2 of 2

Consult received to readdress tube feeds. Spoke with daughter who believed that patient was not receiving adequate free water with feeds however I explained to daughter that additional flushes were being managed by Nephrology as patient had become hypernatremia at beginning of admission with sodium up to 162, D5 started to correct and then switched to flushes of 200ml Q6hr 12/10-12/12 (1800mls total free water with TFs) but then switched to 65ml Q2hrs per sister's request to follow pt's home regimen (total 1780mls with TFs). Sodium first noted to be low at 135 on 12/16 and flushes were decreased to 65ml Q3hrs per nephrology (total 1520mls), has remained this way since and Nephrology signed off on 12/25 as sodium was at goal. Since 12/29 sodium has been low (133, 131, 132, 132) but no changes made to order for TFs or flushes, BUN has been trending high (22.0, 26.0, 27.0). Noted per Nephrology c/s note on 12/10 that sister reported pt usually gets 1.5L of free water via PEG

Admission wt: 48.5kg, updated wt 49.9 kg (today 1/5), wt trend varies likely d/t bed scale being used

Current TF Order: Isosource 1.5 @ 55ml/hr with flushes 65mls Q3hrs (1980 kcals, 90gm pro, total 1550mls free water)
Est Nutr Needs: 1530-1785 kcals (32-36 kcal/kg of admission wt 48.5 kg), 50-76 gm protein (1-1.5 gm/kg)

Brandi Suarez RD
Spectra x63911

Consults by Suarez, Brandi, RD at 1/5/2017 3:21 PM Version 1 of 2

Author: Suarez, Brandi, RD | Service: Nutrition | Author Type: Registered Dietitian
Filed: 1/5/2017 3:23 PM | Note Time: 1/5/2017 3:21 PM | Status: Signed
Editor: Suarez, Brandi, RD (Registered Dieti ian)
Related Notes: Addendum by Suarez, Brandi, RD (Registered Dieti ian) filed at 1/5/2017 5:18 PM

Consult Orders:
1. Inpatient consult to Nutrition [360409867] ordered by Thathagari, Neeraja, MD at 01/04/17 1802

Nutrition:
Consult received, noted per MD's note 1/4 that sister wanted nutritionist revisit about tube feedings but sister not present today and unable to reach via phone, left a message for sister to call me directly and will f/u tomorrow if unable to talk with her today.

Brandi Suarez RD
Spectra x63911

Consults by Armstrong, Kelly at 1/6/2017 7:04 PM Version 1 of 1

Author: Armstrong, Kelly | Service: Ethics | Author Type: Ethicist
Filed: 1/6/2017 8:05 PM | Note Time: 1/6/2017 7:04 PM | Status: Signed
Editor: Armstrong, Kelly (Ethicist)

Ethics meeting held today after the PoA Yolanda Bell was finally located after refusing to return phone calls or make herself available for discussion since December 29, 2016. Multiple calls to the secondary PoA have gone unreturned. Ms. Bell indicates that her home address is [redacted].

Consults by Armstrong, Kelly at 1/6/2017 7:04 PM (continued) Version 1 of 1

The patient is unable to participate in any care planning due to anoxic brain injury after a Tylenol overdose in 2006. According to the medical record, the patient is unable to speak or follow commands at her baseline, with occasional moans during turning/repositioning. There is a Power of Attorney on file dated 2010 naming Yolanda Bell as primary PoA.

During the meeting Dr. David Duncan, Laurel Yee (CM), Linda Soto (Financial services), and myself provided formal notice to Ms. Bell that inpatient services are no longer needed (discharge order 12/28), denials by the relevant health plans, all notices of appeal rights, and presented her with a claim/invoice for services with an estimate of the daily cost of additional care (Financial Responsibility Acknowledgement has been signed). We also informed her that because she had not answered any phone calls or made herself available to speak to the treatment team during business hours for over a week after the denials, that we had no choice but to find that she would not participate in care planning or post-discharge planning despite our repeated attempts to engage her and address her questions.

We further explained that because she has been unavailable to participate in post-discharge planning for an extended period of time after the discharge order had been upheld, we had started the filing to ask the court for a guardian, which would be stopped if she was willing to discharge the patient today -- with a room at Gainesville SNF and transportation already lined up. She merely needed to provide consent. We also explained that once a guardian was put in place, it would be up to the guardian to decide disposition and medical decision-making. Despite this, she continued to indicate that she would not agree to any discharge either tonight or over the weekend. She took copious notes during the meeting (in fact she spent more time taking notes than speaking with us) despite which, she managed to regularly misquote what we were saying. One of Ms. Bell's few questions was why we could not transfer the patient to another hospital. It was again explained that we had previously received no such request, and the patient did not meet the criteria for acute hospital care. She needed a level of care that could be provided at a SNF. She continued to focus on this question until we explained that we can't force a hospital to accept a patient.

Dr. Betzelos, the CMO of IFMC, then came up to speak with Ms. Bell to see what else we could do to help arrange a discharge. During this meeting, Ms. Bell indicated that she didn't understand the reasons for certain decisions and then proceeded to repeat exactly what had been explained to her earlier in the hospitalization. She also indicated that regardless of how dangerous it is to stay in the hospital due to infection risk, she felt the hospital provided far better care than what was available in a SNF and in her estimation, it was better for the patient to remain here for as long as possible.

Appreciate Cardiology coming up after hours to again explain the pericardial effusion (the specific question that the sister indicated had not been adequately explained). The sister indicated that she rejected this second opinion because they were not an independent practice not affiliated with Inova hospital. Credentialing and privileges were explained as was the fact that she was free to seek another independent opinion at another facility after the patient was discharged because the patient was stable. In her questions, the sister demonstrated that she clearly had been told or given these results (repeating exact details from the report such as size, location, secondary findings, how to medically manage the effusion, etc.), but that she rejected these explanations because she felt a limited echo was inappropriate given the situation and the medical management had not been sufficient because the effusion was still there.

Despite multiple attempts to engage her and insurance denying her appeal, the patient's sister continues to refuse discharge and continues to question the conclusions of the patient's care providers despite being provided with second opinions. It appears that all of her questions have been answered, however she does not like the answers being provided and refuses to engage in any discharge planning.

Consults - All Notes (continued)

Consults by Armstrong, Kelly at 1/6/2017 7:04 PM (continued) Version 1 of 1

Ms. Bell had indicated that due to "other plans" she will only be available in person Saturday from 1:30 - 2:00 pm for care providers to contact her. Guardianship proceedings will progress through William Carey of Blankingship and Keith, PC. of Fairfax, VA to find a decision-maker that will participate in care planning and discharge. Encourage physicians and providers to answer any lingering questions that the sister may have over the weekend.

Kelly Armstrong, PhD
Director Clinical and Organizational Ethics
703-776-2643; pager 38442

Consults by Suarez, Brandi, RD at 1/16/2017 3:41 PM Version 1 of 1

Author: Suarez, Brandi, RD | Service: Nutrition | Author Type: Registered Dietitian
Filed: 1/16/2017 3:41 PM | Note Time: 1/16/2017 3:41 PM | Status: Signed
Editor: Suarez, Brandi, RD (Registered Dieti ian)

Consult Orders:
1. Inpatient consult to Nutrition Services [362241934] ordered by Thathagari, Neeraja, MD at 01/15/17 1633

Nutrition:

Consult received, discussed with Dr Thathagari and RN, attempted to reach sister via phone but did not answer and voice mailbox was full. Will re-attempt. I have been following this patient closely and noted all changes made.

Additional rec: If loose/liquid stools continue, recommend adding risaquad probiotic and starting Nutrisource Fiber 2 packets BID

Patient's current TF order is for TwoCal @ 35ml/hr with 1 Prosource and 2 Juven, providing 1860 kcals (39 kcals/kg) and 81 gm protein (1.7 gm/kg) which is in the range of 35-40 kcal/kg used for weight gain and the protein range appropriate for skin breakdown. I also added Juven 2 packets daily to support healing of skin breakdown which also adds calories (sister likely not aware of this). Patient's admission weight was 48.5kg with a trend up to ~55kg however all of these recorded weights were taken using the bed scale due to patient's inability to use a standing scale and therefore have questionable accuracy. The decrease to 45 kg was recorded on 1/15 (yesterday) and again today at 45.269kg. As per table below, weights are greatly varied even from one day to the next so if patient's sister is asking for her weights on a daily basis, she should understand the likeliness of inaccuracy. I also discussed with nursing who did not realize that patient is ordered for Prosource AND Juven, so patient may have missed some of the additional protein and calories over the past few days.

The current TF regimen is appropriate to meet estimated needs and I defer management of additional free water to Nephrology. Continue to trend weights with as few items (pillows, blankets, other devices) on the bed as possible.

Weight Monitoring	Weight
12/1/2016	48.535 kg
12/2/2016	51.665 kg
12/4/2016	53.887 kg
12/5/2016	57.607 kg
12/6/2016	55.656 kg

12/7/2016	54.432 kg
12/8/2016	58.968 kg
12/9/2016	58.968 kg
12/10/2016	53.524 kg
12/11/2016	53.524 kg
12/12/2016	53.524 kg
12/13/2016	53.524 kg
12/14/2016	53.524 kg
12/15/2016	52.164 kg
12/16/2016	53.978 kg
12/17/2016	48.58 kg
12/18/2016	49.896 kg
12/19/2016	54.432 kg
12/20/2016	54.432 kg
12/21/2016	54.432 kg
12/22/2016	54.885 kg
12/23/2016	54.885 kg
12/24/2016	55.792 kg
12/25/2016	55.792 kg
12/26/2016	56.246 kg
12/27/2016	53.343 kg
12/28/2016	53.343 kg
12/29/2016	53.34 kg
12/30/2016	53.34 kg
12/31/2016	50.803 kg
1/1/2017	52.164 kg
1/2/2017	52.617 kg
1/3/2017	52.164 kg
1/4/2017	52.164 kg
1/5/2017	49.896 kg
1/6/2017	52.164 kg
1/7/2017	49.896 kg
1/8/2017	49.896 kg
1/9/2017	49.896 kg
1/10/2017	49.896 kg
1/11/2017	48.081 kg
1/12/2017	49.442 kg
1/13/2017	49.896 kg
1/14/2017	49.924 kg
1/15/2017	45.768 kg
1/16/2017	45.269 kg