**King University MSN/NP Program** 

**Clinical SOAP Note #4**

**Adult & Geriatrics**

**Student:** Angel Hobbs **Course:** NURS5019

SOAP Note #4 Geriatric Patient

 Pt. Initials: R.J. Age: 66 DOB: 07/07/1953 LMP: N/A

**Subjective: Chief Complaint:** 66 y/o male presents today with complaints of fatigue and musculoskeletal pain. Pt states the pain is mainly in his lower extremities and he fatigues easily with any form of exercise or normal daily activities. The patient states legs have a weird cramping like pain in them. The pain is aching and burning with numbness in tingling in calve muscles. Reports occasional dizziness when standing. Patient also states these symptoms have been persistent for about 3 months.

**HPI:**

**Character:** Burning, tingling, cramp like pain in lower extremities.

**Onset:** Symptoms started 3 months ago

**Location:** Bilateral lower extremities

**Duration:** Intermittent times of the day. Happens daily

**Severity:** rates pain at 6-7

**Pattern:** Intermittent throughout the day

**Associated:** No associated factors. No injury.

**Medical Hx:**

Hypertension

Smoker

**Surgical Hx:**

None

**Social Hx:**

Pt lives at home with his wife. Children are grown and live in area. Retired truck driver. Denies alcohol use, denies vaping, denies illicit drug use. Pt drinks caffeine (approximately 4-5 cups of coffee per day), Pt is a smoker (1-2 PPD).

**Family Hx:**

Father- Hypertension, Alcoholism, Asthma

Mother- Hypertension, Alcoholism

**Medications:** Lisinopril 20 mg one tablet po BID

**Allergies: PCN/Anaphylaxis**

**Review of Systems:**

**General:** Affect appropriate. Pleasant and cooperative.

**HEENT:** Denies pain in ears. Denies drainage from eyes or nose. Denies sinus pressure. Denies burning or discomfort in throat and mouth.

**Skin:** Denies bruising, rashes or lesions

**Respiratory:** Positive for cough. Denies difficulty breathing.

**Cardio:** Denies chest pain or discomfort. Denies palpitations.

**GI:** Denies abdominal discomfort. Denies constipation, diarrhea, nausea and vomiting.

**GU:** Denies dysuria, hematuria, polyuria, frequency, retention and incontinence.

**Diet:** Denies excessive fried foods. States wife cooks every night. Watches his sodium intake with diet.

**Endocrine:** Denies fever or chills. Positive for fatigue.

**MS:** Positive for muscle pain and discomfort in bilateral lower extremities.

**Neuro:** Positive for tingling, weakness, cramping sensation in bilateral lower extremities.Positive for dizziness when standing.

**Psych:** Denies depression. Denies thoughts of suicide or harming others.

**Objective:**

**Vital signs:** T: 98.4 P: 99 R: 20 BP: 112/75 HT: 6’2” WT: 196 BMI: 24 Pain: 6-7/10

**Constitutional:** Very pleasant, well developed, cooperative 66-year-old Caucasian male. Clean, well groomed, and dressed appropriately. Makes good eye contact. Good historian. Affect is appropriate. A&O x’s 3.

**HEENT:** Auditory canal is clean and free of debris. Tympanic membranes are intact, pearly gray in color, with no erythema noted. Nasopharynx is pink and moist with noted right sided nasal septum deviation. Oropharynx is pink and moist. No erythema noted. No exudate or lesions noted. Uvula is midline. Upper and lower dentures are noted.

**Skin:** Warm, dry, intact. No tenting, swelling or bruising noted. Bilateral spider veins to ankles and feet noted. Dry flaky lesions to scalp.

**Respiratory:** Respirations even, regular and unlabored. No adventitious sounds heard throughout lung fields.

**Cardio:** S1, S2 heard. No murmurs, rubs, or gallops heard.

**GI:** Normoactive bowel sounds heard in all four quadrants. Abdomen soft, and non-distended. No pain or discomfort with palpation.

**GU:** Not assessed

**Endocrine:** No cervical or supraclavicular lymphadenopathy noted.

**MS:** Full ROM with cervical and lumbar spine. No visible abnormalities with arms, legs, hands and hips. Positive for bilateral muscle pain in lower extremities. No edema or erythema noted to bilateral lower extremities.

**Neuro:** CN 3, 4, 6 and 12 intact. PERRLA. Grips are equal and strong. Positive for numbness, tingling and pain in bilateral lower extremities. Positive for weakness in bilateral lower extremities.

**Psych:** A&O to person, place and time. Cooperative with health care.

Other: N/A

**Assessment:**

**Dx:**

Peripheral Arterial Disease (I73.9)

Intermittent Claudication (I70.213)

Hypotension d/t over medication (I95.2)

Actinic Keratosis (L57.0)

Fatigue (R53.83)

**Differentials:**

1- DVT (I82.40)

2-Orthostatic hypotension (I95.1)

3- Arthritis (M19.90)

**Plan:**

1: Fatigue

CBC with diff, CMP, TSH, Vitamin B-12, Folate, Vitamin D hydroxy, and Testosterone levels to be drawn today ($30.00 co-pay with insurance)

2: Peripheral arterial disease and Intermittent Claudication

Compression hose ordered today 15-20MMHG ($15.00 at DME)

Start patient on Pletal 100 mg BID (take before or 2 hours after meals) #60 with 2 refills ($27.88 with GOOD RX)

Refer to Vascular surgeon- Dr. Shahin Assadnia ($30.00 copay)

3: Actinic Keratosis

Refer to Dermatology Associates of Kingsport ($30.00 copay)

4: Hypotension d/t over medication use

Decrease Lisinopril to 10 mg BID. ($12,27 with Good Rx)

Bring Blood Pressure diary to next visit

Obtain orthostatic blood pressures in office today

 **Pt.Education:**

1: Smoking cessation

2: Check B/P every day and bring B/P diary to next visit

3: Watch diet and increase fluid intake. Avoid excessive amounts of caffeine.

4: Tylenol or Ibuprofen as needed for pain

5: Bleeding precaution education

**Preventive care:** Use caution with taking new medication. Take B/P daily. Use fall precautions

**Follow-up instructions:** RTO 1 month

**Other:** Will re-evaluate pain level next visit. Will obtain records from Dermatology and Vascular surgeon after referral appointment.

**Geriatric Toolkit Assessment:**

**Clock Drawing Test-** Pt drew perfect numbers on the clock and straight hands pointing to 5 o’clock. Score=**1**

**Geriatric Depression Scale-** Pt was screened with the Geriatric Depression Scale (short form). The patient was asked to take time and answer the questions honestly. Score= **1**

**Get up and Go Test-** Pt was asked to sit comfortably in the straight back chair instead of the table, rise up from the chair, stand momentarily, walk out of the room to the end of the hall, turn around, walk back to the chair, turn around, and sit back down in the chair. Pt only complained of slight pain in lower extremities when standing. Score=**2**

**Instrumental Activities of Daily Living**- Pt was asked to fill out survey on his own. According to the patient, he can do everything on the list by himself with no complications, but feels his wife is responsible for cooking. Score= **7**

**Medication and Falls Risk Chart**- The patient takes Captopril 20 mg one tablet po BID. Pt had presented with c/o slight dizziness when rising from a sitting position. Original intake B/P in sitting position was 112/75. Orthostatic B/P’s were obtained and showed no significant drop in B/P when standing. Orthostatic B/P’s- Sitting: 114/72, Standing: 112/69, Lying: 118/75. PT was checked for s/s of sinus pain or pressure and was negative. Pt’s ears were checked for fluid build up behind TM and was negative. Pt’s B/P medication was decreased to Captopril 10mg one tablet po BID. Pt was started on Pletal this visit for PAD and IC. Pt was educated on bleeding precautions with this particular medication. Pt will follow-up in 1 month and bring a daily blood pressure log with him to next appointment. According to the Agency for Healthcare Research and Quality (2013), “Antihypertensives, cardiac drugs, antiarrhythmics, and antidepressants can induce orthostasis, impaired cerebral perfusion, and poor health status. These medication classes rate at a medium risk. Score=**2**

**Nutritional Health Assessment-** Pt was asked to read and fill out Nutritional Health Assessment. Pt states he only associates himself with the first question. Pt states he had to change his diet d/t Hypertension, and follows a low sodium diet. During my initial assessment, I discussed increasing fluid intake with water and decreasing amount of caffeine consumed daily. Score= **2**.

As stated previously, Pt’s B/P medication was decreased this visit. He was also educated on increasing fluid intake and decreasing caffeine via written and verbal education. Pt was instructed to use fall precautions regardless of his low scores and bleeding precautions with new medication Pletal. Pt was instructed to RTO in 1 month to follow-up on medications and new referrals.

**3 NONPF Competencies:**

I feel the three competencies that were addressed during this visit were Quality Core Competency, The health delivery system core competency, and Leadership Competency.

* Quality was addressed by tailoring to the patient’s particular needs and situation by using interventions as necessary. Not only did the patient receive a referral to dermatology, but he also received a referral to a vascular surgeon and was started on treatment for intermittent claudication. We also drew labs to find the root cause of the fatigue. The patient was also treated for hypotension d/t taking too much blood pressure medication. I decreased his B/P medication by half.
* The Health Delivery System was used to collaborate with our on site DME for the proper compression stockings and price. We decided on 15-20MMHG for the patient. I also collaborated with a local pharmacy to find the price of the Pletal for the patient.
* Leadership was demonstrated by providing the patient with excellent oral and written communication. Using critical and reflective thinking for diagnosing, education, and medication regimen.

**References:**

Tool 3I: Medication Fall Risk Score and Evaluation Tools. (2013). Retrieved 1 July 2020, from https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3i.html