Case studies:

To use in weekly sessions
for facilitating interprofessional education
in the rural health care setting

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Rural Interprofessional Clinical Education (RICE)

University of Ottawa and St. Paul's University

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Ms. Dubé
Case Study
Developed by Dr. Paul Coolican, Family Physician, WDMH

Ms. Dubé is an 81 year old widow who says she was trying to put up a few lights for Christmas when she slipped and hurt her leg. She is not big on details but does say it happened 2 days ago. She looks disheveled, is a bit agitated and cannot stand. Her pulses are palpable in the foot and there is normal colour. The foot is a bit swollen and the left leg seems a bit shorter. Her pulse is 100 and a bit irregular. Her x-ray shows a displaced subcapital fracture of the left hip.

She is admitted to hospital and a consult is sent to orthopedics. When she is told that she needs an operation to fix it, she replies “I am not having an operation, thank you very much!” On review of her chart it is discovered that there is no listed next of kin and she has been widowed for 8 years with no immediate family. She has been active at the Church and still goes weekly and to most Church events. Her Family Doctor sees her every 3-6 months for hypertension and hypothyroidism. Ms. Dubé has no living will.

Suggestions for discussions:

1. Patient’s needs.
2. Roles of different health care providers with this case.
3. Ethical dilemmas.
4. Patient’s adherence to plan of care.
5. Social / cultural issues.
6. Effect of cognitive issues.
7. Any conflict.

Mrs. Marleau
Case Study
Developed by Ms. Joanne Sidorchuk, Physiotherapist, WDMH

Mrs. Marleau is an 83 year old woman with type II diabetes transferred from a large hospital 1 week after a major CVA. She immediately likes the small rural hospital and knows several of the other in-patients. The nurses in the Complex Continuing Care Unit are all very nice to her and even put her hair in curlers. She has several visitors each day, most of them she knows from her church. Some of the visitors bring her home cooked food and baked goodies.

The day after admission to the hospital the occupational therapist, physiotherapist and dietician all come to assess her. There is no social worker at the hospital. The Occupational Therapist finds that her short-term memory is poor and that Mrs. Marleau requires total assist with ADLs to get dressed. Mrs. Marleau requires two people to assist for all transfers. Transfers are very difficult and staff is afraid the patient will fall. The Dietician meets with Mrs. Marleau as she is concerned about her weight of her 190lb to see if she is following her diet. Mrs. Marleau says she follows her diet to a "T", but the dietician notices half a box of Tim Bits beside her bed and several plastic containers with baked goods inside.

Mrs. Marleau lives alone in a one storey bungalow in the country. Her husband was a prominent local family physician who passed away a year ago. The couple had a very active social life and had donated over $500,000 to the hospital a few years ago. Her only son is a lawyer in Ottawa who has yet to visit her in the hospital since her stroke.

Mrs. Marleau was using a walker before the stroke and her son had a ramp built for her to get into the house. He had also bought her a raised toilet seat and an electric Lazy Boy. She had tried "Meal-On-Wheels" in the past but didn't like the food so she prepares her own meals. Even though she has a driver's license she is nervous behind the wheel and only drives into town when the roads are clear. She has a cleaning lady so the house is always tidy for her visitors.

Her progress is very slow. After four weeks, two people are still required to help her into a wheelchair and there are no signs of improvement in her memory. Mrs. Marleau is always in a good mood. Everyday as she leaves therapy, she smiles and says, "That's OK, I'll get better by myself when I get home."

The care team discusses her case frequently and is concerned about her recovery. The team feels that she needs a lot more therapy if she intends to return home, and may not even be able to return home. Every time they mention the advantages of going to rehabilitation in the city Mrs. Marleau says she is happy here and doesn't want to go, and besides, the city would be too far for her friends to drive to visit her.
While the team is discussing her prognosis, a team member comments, "Good luck, you know that doctor has a reputation for doing whatever the patient wants" and was a good friend of the patient's deceased husband.

Suggestions for discussions:

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2. Roles of different health care providers with this case
3. Ethical dilemmas.
4. Patient's adherence to the plan of care.
5. Social / cultural issues.
6. Effect of cognitive issues
7. Any conflict.

Mrs. Ethier
Case Study
Developed by Lynn Hall, Nurse, WDMH

Mrs. Ethier is an 82 year old woman who lives alone. She has been a widow for 10 years. She lives in a large farm house on her own. Mrs. Ethier's closest neighbor, Grace, lives 2 kilometers away. She has lived in this same home since birth. Mrs. Ethier does not socialize at all, belongs to no clubs and does not attend any type of social gatherings since her husband passed away. Her husband, Norman, died suddenly following complications post-heart surgery. Norman was the one who handled all of the money, paid the bills, ensured that Mrs. Ethier attended doctor's appointments regularly and made all of her appointments. They had no children. Mrs. Ethier was an only child and Norman had one sister, who passed away 1 year ago. They had one niece, Ester. When Norman passed away his sister became power of attorney for both finance and health. After his sister died, there were no other close relatives, and Ester agreed to become the power of attorney for health and finances.

Mrs. Ethier was admitted to hospital 2 weeks ago. She was admitted with a very high fever, chills, and confusion. Upon admission she was not oriented to person, place or time and had periods of hallucinations. After numerous tests Mrs. Ethier was diagnosed with urosepsis and dehydration. As well on admission it was noted that Mrs. Ethier had poor hygiene and numerous skin abrasions and bruises.

Once the urosepsis was treated and Mrs. Ethier was rehydrated with IV fluids, a consult was placed to discharge planning. The discharge planner placed numerous calls to Ester with no success. The nurses mentioned to the discharge planner that the neighbor visits daily and had expressed concerns. The discharge planner met with Mrs. Ethier's next door neighbor Grace. Grace explained that she has been visiting and helping Mrs. Ethier daily over the past few months. She picked up the weekly groceries, helped with laundry and personal care.

Grace had noted a decline in Mrs. Ethier's "mind" over the last year. Grace also found Mrs. Ethier becoming increasingly abrupt in her responses, angry when she could not remember what she wanted to say and would often pound the table. Two months ago Grace was concerned with her safety. She found the stove on and the kettle boiled dry. Grace found that the door was often locked and Mrs. Ethier would not answer the door, forcing Grace to use the key that was hidden under the mat.

Grace had called Ester a number of times to explain the situation but felt that Ester cut her off and did not listen to her. One month ago Ester told Grace that she should not visit on a daily basis, that Mrs. Ethier was relying on her too much and that Grace was not to do the groceries any longer and, if she did, she would not receive any money for the groceries. Nevertheless Grace stated she continued to visit Mrs. Ethier and noticed a decline in her well-being. Grace was concerned that Mrs. Ethier was not receiving the care she required to maintain a healthy life and remain safely in her home. Grace stated she had started discussions with Mrs. Ethier regarding a nursing home or residence. Mrs. Ethier was very open to this idea but stated that Ester said she could not afford it and it was better for her to stay in her own home.

During the team discharge meeting, Mrs. Ethier stated numerous times she wanted to go home. She felt she could look after herself with some assistance. Ester felt she could go home as well, and felt Mrs. Ethier could look after herself with Ester's help.

Suggestions for discussions:

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2. Roles of different health care providers with this case
3. Ethical dilemmas.
4. Patient's adherence to the plan of care.
5. Social / cultural issues.
6. Effect of cognitive issues
7. Any conflict

Mrs. Weeble
Case Study
Developed by Yolanda Prange, Physiotherapist, Renfrew Victoria Hospital

Mrs. Weeble, 88 yrs old, came to the ER department by ambulance. She was found at home, lying in her bathroom by the police, after they had been contacted by her daughter. Her daughter Sue, who lives 50 kms away, became concerned when her mother had not answered the telephone for the day. When the ambulance arrived Mrs. Weeble was unable to stand up or bear weight through her right leg, she complained of excruciating pain in her groin when her right leg was moved. She reported that she slipped on the throw rug when she was walking to her bathroom at night.

Mrs. Weeble is diagnosed with a subcapital hip fracture, communited. She went for Orthopaedic surgery and the fracture was stabilized with a pin and plate.

On the third day post-op, Mrs Weeble became confused, and unable to follow commands. She had a large blackened area on her right heel.

After a week, Mrs. Webble's confusion has improved significantly. She is anxious to get moving so she can return home to take care of her cat. She lives in a two storey home and usually prepares all of her meals. She reports that she has been having trouble getting around her home and that she has had a number of falls in the past.

Suggestions for discussions:

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2. Roles of different health care providers with this case
3. Ethical dilemmas.
4. Patient's adherence to the plan of care.
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6. Effect of cognitive issues
7. Any conflict.

Ms. Booth
Case Study
Developed by Wilma Jelley,
Physiotherapist, University of Ottawa

Ms. Booth is a 41 year old single mother who works for the local Independent Food Store.

Ms. Booth was diagnosed with pulmonary emphysema 1 year ago. She has smoked a pack of cigarettes a day since age 15. Since she was diagnosed, she has tried to reduce her smoking to 5 cigarettes per day. She feels guilty about her inability to stop smoking. She has had a chronic nonproductive cough. She has one daughter, 20 years of age, who is in her 3rd year of the nursing program at the University of Ottawa. Her daughter keeps on nagging her to stop smoking every time she sees her.

Ms. Booth was admitted through emergency with significant dyspnea and chest pain on little physical effort. Ms. Booth explained when she arrived home from work she was not able to climb the stairs to her apartment over the pharmacy. She had sat on the steps and could not move due to the pain in her chest. She was terrified, because she has never experienced this pain and telephoned a friend on her cell phone and who drove her to emergency.
On examination, she was thin, tired, anxious and wheezing. She was tachypneic, tachycardiac and afebrile with a normal blood pressure. She had no peripheral cyanosis. An x-ray shows hyperinflated lungs ++ and cardiomegaly. On her EKG she had sinus tachycardia with no obvious ischemic changes. Routine blood work was normal and cardiac enzymes did not reveal any acute cardiac injury. Her O2 saturation was 90% on room air. Arterial blood gas analysis revealed a mild respiratory alkalosis with mild hypoxia and low carbon dioxide.

<u>Medications:</u>
Tiotropium inhaler bid
Inhaled corticosteroid (Advair) prn
Iron
Calcium

Suggestions for discussions:

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Ms. Leslie
Case Study
Developed by Peter Barnes, Professor, St. Paul University

Leslie is a 56 year old single woman who lives on her own near a small town in rural Ontario. She had a career as a high school math teacher who was forced to go on long-term disability three years ago. She has rheumatoid arthritis that has seriously impaired her mobility and the use of her hands. Her two younger siblings who live near by have reported that she has always been fiercely independent and is a stubborn person. She cared for their parents in the family's two-storey farm house until their deaths ten and four years ago. She manages her pain with hot packs and refuses to go to the hospital until it is absolutely necessary. She stopped taking her arthritis medication, NSAIDs and steroids, due to the side effects.

At her sister's insistence she presents to the emergency department with right knee pain, swelling, redness and hot to touch. Although she denies that her symptoms impair her mobility, upon examination she cannot stand up on her own, and is only able to take a few steps with help from two nurses. When she goes to hospital she begins immediately to insist upon being returned to her home. Even though when she is in hospital she is encouraged to follow the treatment protocol she is adamant that she knows what she needs and refuses to comply. As a result her condition is progressively deteriorating and there is less and less movement in her legs. There is a concern by the care teams in both the hospital and the community that she is deteriorating and that she will soon have to consider alternative living arrangements that will provide more assistance with her movement. She continues with a high carbohydrate diet and with the reduced mobility she is gaining weight.

Her colleagues at the school where she taught were her closest friends, but since she has been off on disability they have slowly disappeared. Ms. Leslie's family is very worried about her and they have expressed their concern to her but she ignores their pleas. In addition they have spoken to Ms. Leslie's doctor that something has to be done before she falls and seriously hurts herself.

Suggestions for discussions:

1. Patient's needs.
2. Roles of different health care providers with this case.
3. Ethical dilemmas.
4. Patient's adherence to plan of care.
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7. Any conflict.

Mrs. Smith
Case Study
Developed by Dr. Paul Coolican, Family Physician, WDMH

Mrs. Smith, age 43, is admitted to the hospital one year after an extended radical mastectomy. Mrs. Smith is married with two daughters, age 7 and 9 years. She has undergone a series of radiation treatments following surgery and is being treated with testosterone propionate for metastases at the time of this hospital admission. The physician informs the patient's husband that his wife is not expected to live very long.

The patient refuses to take pain medication and she is fully cognizant of the prognosis and aware of the rapidly deteriorating condition of her body. Mr. Smith accompanied his wife when she was admitted to hospital. He also observed Mrs. Smith giving to the admitting nurse a sheet of paper on which she stated that she did not want to be resuscitated. Mrs. Smith was fully competent at the time of her admission and she was not taking any medication which would have affected her decision.

Following admission to the hospital, during a one month period of time, Mrs. Smith continues to deteriorate physically, but she is still alert and orientated. Her children and family visit her frequently. Following a conference with the care team, Mr. Smith demands that Mrs. Smith be coded if she has a cardiac arrest. That evening Mrs. Smith arrests.

Suggestions for discussions:

1. Patient's needs.
2. Roles of different health care providers with this case
3. Ethical dilemmas.
4. Patient's adherence to the plan of care.
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6. Effect of cognitive issues
7. Any conflict.

Mrs Coff
Case Study
Developed by Maureen Magill Respiratory technician and Shawn Silver Physiotherapist, Renfrew Victoria Hospital

Mrs. Coff is a 69 year old woman with a diagnosis of Emphysema. She was a heavy smoker until 4 years ago. At that time, she had an 80-pack year history of smoking. She has been symptomatic with dyspnea on exertion for the past 8 years, with some pronounced deterioration in function over the last two years. She has had two previous hospitalizations for infectious exacerbations of her COPD. She was independent in activities of daily living prior to this admission. However, her exercise tolerance was reduced by dyspnea that occurs after one or two blocks of walking on a flat surface or climbing more than one flight of stairs.

Mrs Coff is a widow. She has 2 children; a 45 year old daughter in Ottawa and a son of 41 who lives in Red Deer. Mrs Coff had been referred to Respiratory Therapy by her family physician.

	At Rest	After 6 Min Walk
Supplemental Oxygen?	Room Air	Room Air
BP	105/70	120/80
HR	72	106
RR	20	20
SOB Scale	0.5/10	4/10
O2 Saturation	96%	88%

Pulmonary Function Tests were also performed. In addition, a questionnaire used to assess qualify of life, SF36, was administered.

Six weeks later, Mrs. Coff was discharged from the program. Throughout the program, Mrs. Coff was very motivated and cooperative. Mrs. Coff accomplished a great deal despite the fact that her distance walked in 6 minutes did not change significantly. On the day of discharge, she was able to demonstrate her ability to perform diaphragmatic breathing, SOS for SOB, pulse taking, controlled cough, pacing and coordination of breathing with activity.

On her first follow up visit, Mrs Coff reports to not be doing her home exercises, following her treatment plan or to regularly taking her medications. She says, “What is the use? I am not going to get any better. There is no cure for emphysema. This is pointless. Why am I putting myself through this?”

Two Months Later

Mrs Coff has been admitted to hospital with increased sputum due to an URTI and spiking a fever. She has noted a change in the colour of the secretions to a dark green in the morning. She also complains of episodes of night sweats, occasional mild swelling of her ankles and orthopnea. She is unable to sleep the whole night at this time and is very fatigued.

On examination, there is marked accessory muscle use. Her respiratory rate is 30 breaths per minute and there is intercostal indrawing and Mrs. Coff states "No, you don't know how I feel!!!!! You are not short of breath whenever you get up! You don't know what it is like to live with a chronic breathing problem…"

On auscultation, she has decreased breath sounds bilaterally in the posterior basal segments, low pitched wheezes transmitted throughout the lungs and coarse crackles in the left upper lobe.

Suggestions for discussions:

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7. Any conflict.

Mr. Jones
Case study
Dr. Paul Coolican, Family Physician, WDMH

Mr. Jones is a semi retired farmer of 78. He is a heavy smoker and a poorly controlled type II diabetic. He presents at the hospital very short of breath. His blood work indicates that he has had a myocardial infarction. He is found to have large lesions in both lungs. He feels that he has lived a good life and is content to let nature take its course. His family fully supports his decision and after discussing it with the patient and his family, the nursing staff documents a DNR request on his chart.

The next day the physician spoke with the patient and convinced him to rescind the DNR and accept aggressive exploration of his condition stating that without further investigation a definite diagnosis would not be known.

After several ambulance trips into The Ottawa Hospital for scans and tests over the past 10 days, Mr. Jones has returned to the rural hospital. At 8:53 a.m., as the interprofessional team is doing rounds on the floor, he arrests.

Suggestions for discussions:

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7. Any conflict.

Mr. And Mrs. Hébert
Case Study
Developed by Brigitte Johnstone, Physiotherapist, University of Ottawa

Mrs. Hébert is an 85 year old woman, who has a pneumonia and upon admission to the hospital. She has late onset of non-insulin dependent diabetes controlled with diet and oral medication. She has well controlled mild hypertension and osteoarthritis treated with mild analgesics. Mr. Hébert has mild to moderate dementia and was unable to remain at home alone, he therefore was also admitted. Mr. Hébert who is 86 years of age wanders if he is not monitored constantly. The couple has been living in their own home in rural Ontario which is 10 kilometers from the nearest town. The closest neighbour is 2 kilometers away. Their children and grandchildren live in the city about two hours away and visit whenever possible.

This is the third time in the past 18 months that Mrs. Hébert has been admitted due to an infection. The interprofessional team is questioning the state of her health and the couple's ability to live independently.

Medications:
Gliclaszide
Cardizem
Hydrochlorthizide
Plavix
Acetominophen

Suggestions for discussions:

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7. Any conflict.

Mr. Vaughn
Case Study
Developed by Joanne Sidorchuk, Physiotherapist, WDMH

Mr. Vaughn is a 75 year old man who had hip surgery 5 days ago to repair a fractured femur. On return to the rural hospital from the city hospital he is on MRSA Contact precautions.

The newly graduated spiritual care worker, Faith, has received a referral to see Mr. Vaughn. Faith decided to work in this small rural hospital so she could care for her ailing grandmother. Ever since the chemotherapy started her grandmother has been too weak to do her ADLs and Faith has been caring for her before and after work. Faith is careful to follow infection control protocol, as she is aware the treatment leaves her grandmother immune suppressed.

Faith reviews the patients chart and goes to his room. Taped to the doorframe is a yellow sign saying "MRSA Contact Precautions" indicating that everyone who enters the room must wear a gown and gloves and that any equipment taken into the room must be left there.

Faith introduces herself. Mr. Vaughn says "I was hoping you would come. I had my fall six days ago and I missed Easter Mass. Please Faith, can we pray together?" Faith agrees. Mr. Vaughn reaches for Faith's hand. Can you please take off your gloves I hate the feel of vinyl." Faith replies she is required to follow protocol and cannot remove her gloves.

Mr. Vaughn seems bothered, "They don't all wear the gown and gloves, the girl who took my blood didn't bother. Yesterday the nurse told my friend he didn't have to bother to get all dressed up, that these precautions were ridiculous." Mr. Vaughn mumbles something about his doctor not even wearing gloves, grabs his rosary beads and turns away from Faith.

Faith leaves the room and walks back to the nurse's station. She finds the charge nurse, and relays what she just heard. The charge nurse says "Yes, we all know about the frequent breeches on infection control. But what can we do?.

Suggestions for discussions:

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2. Roles of different health care providers with this case
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6. Effect of cognitive issues
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Mr. Sharpe
Case Study
Developed by Brigitte Johnstone, Physiotherapist, University of Ottawa

Mr. Sharpe is a 50 year old male who developed slurred speech, right arm and leg numbness when he awoke one morning. He, his wife and two children live in a rural community. He is a self employed chartered accountant; his wife is at home with two boys' age 12 and 10. The 10 year old boy is autistic.

Mr. Sharpe was brought to the emergency and admitted at the local hospital. He suffered a thromboembolic stroke and will remain in hospital. Past medical history includes untreated atrial fibrillation and untreated essential hypertension.

He has no benefits, and the family must sell their house and car to manage finances. The wife is unable to work; she must care for her autistic child.

Six months have passed. Recovery is slow at best. Mr Sharpe is now following rehabilitation, but is still bedridden or can be sitting assisted. He has some difficulties swallowing and is not able to communicate effectively. He will be able to soon come home on weekend visits. He has been prescribed anticoagulants and antihypertensive medication.

<u>Medications;</u>
Coumadin
Chlorthalidone
Perindopril (ACE Inhibitor)

Suggestions for discussions:

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6. Effect of cognitive issues.
7. Any conflict.

Mr. Edwards
Case Study
Developed by Dr. Paul Coolican, Family Physician, WDMH

Mr. Edwards, age 76, has been admitted to hospital with a “heart attack” after 2-3 days of chest pain. He seems a bit confused and upset by all the fuss around him. Medically he would benefit from going up to Ottawa for angiography and possible intervention. When this is discussed with him he has no response. Finally after being asked whether he would be willing to go to Ottawa for these interventions, he looks up and replies, “You do what you think is best.”

Hospital staff is considering arranging for an ambulance to transport him to the Heart Institute in Ottawa. Staff wants Mr. Edwards to make a decision within the hour. They discuss the situation with his next of kin, a son who works in Yellowknife and run a screening test for Dementia. While waiting Mr. Edwards is treated conservatively with medication.

His past medical history includes few visits to the doctor in last 10 years. He had been prescribed Aspirin (ASA) and pills for high blood pressure and high cholesterol in the past, but has not filled any prescriptions for more than 2yrs.

Mr. Edwards’ wife died of endocarditis in Ottawa 15 years ago. He was raised as a Lutheran but has not been active as a church member for last 10 years. He was the eldest son and took over the family farm. His siblings have died of cardiac conditions or moved away. Mr. Edwards had 2 children, 1 died in an accident in 1980 and his youngest son works as a miner near Yellowknife. Mr. Edwards lives in old farmhouse, the farm is currently not active and he has been isolated for the past 10 yrs. His neighbours mentioned the house was in disrepair and dirty.

Suggestions for discussions:

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2. Roles of different health care providers with this case.
3. Ethical dilemmas.
4. Patient’s adherence to plan of care.
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6. Effect of cognitive issues.
7. Any conflict.

Mr. Thick
Case Study
Developed by Wilma Jelley,
Physiotherapist, University of Ottawa

Mr. Thick is an 82 year old man who has worked all his life in the family Feed and Seed Store. He continues to help his son and daughter-in-law at the store.

He has been admitted to hospital due to severe lumbar back pain (9/10) for approximately 10 days. The patient's son reports that his father had two falls in the past two weeks – he complained that his legs "gave out".

He has had a history of similar back pain and had a discoidectomy and fusion done of L3-4 eight years ago. The surgery reduced the pain and eliminated the neural signs. X-rays indicate osteoarthritis in L2 to L5 and left hip and knee.

He drives himself to work and home. Mr. Thick lives alone, about 15 minutes out of town. His wife died of breast cancer 28 years ago. The patient's son and daughter in law are very concerned because of his age, that his level of autonomy is changing and he is still driving.

Medications:
Furosemide bid
NSAID (Celebrex) prn
ASA daily

Suggestions for discussions:

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2. Roles of different health care providers with this case
3. Ethical dilemmas.
4. Patient's adherence to the plan of care.
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6. Effect of cognitive issues
7. Any conflict.

Mr. Harper
Case Study
Developed by Paul Buchner, Pharmacist and Dr. Steve Radke,
Renfrew Victoria Hospital

Mr Harper is a 30 year old male, married with no children, finished grade twelve, does lawn care in the summer, snow removal in the winter, never smoked, rare alcohol consumption.

He developed insulin dependant diabetes mellitus (IDDM) at age one and epilepsy at age 22, has been seizure-free for five years. Dislipidemia. No vision in left eye due to retinal detachment. He has chronic renal insufficiency requiring hemodialysis three times weekly. Mr Harper has Trillium Drug Plan. Mr Harper is a potential candidate for transplant.

He presents by ambulance to the local ER after having a witnessed seizure while clearing snow in Mary Jane Howard's lane way.

Medications:
tegretol CR 400mg at bedtime (epilepsy)
furosemide 120mg every morning, 80mg each afternoon (blood pressure/fluid)
atorvastatin 40mg each evening (for cholesterol)
metoprolol 100mg twice daily (blood pressure)
replavite once daily (multiple vitamin)
adalat XL 60mg once daily (blood pressure)
atenolol 50mg once daily (blood pressure)
TUMS 4 with meals (phosphate binder)
Insulin Lantus 20U once daily (diabetes)
Insulin Regular 4U with each meal (diabetes)
telmisartan 80mg once daily (blood pressure/heart disease prevention)
erythropoietin 2000U three times weekly (increases red blood cells)
iron sucrose 100mg IV monthly (iron supplement)

Suggestions for discussions:

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John
Case Study
Developed by Brigitte Johnstone, Physiotherapist, University of Ottawa

John is a 6 year old boy who pulled a frying pan of hot fat off the stove and had 3rd degree burns to his right hand and arm. He was brought to the emergency department and admitted to the local rural hospital. He is on pain medications, IV and the burn is dressed. The parents have been bickering since arrival at the hospital.

This child comes from a family where the parents are no longer together. There are issues between the parents. The father has alternate weekends with his son. The accident occurred on a Saturday evening of a weekend visit with his dad and his new girlfriend.

John is an otherwise healthy 6 year old who is doing well in grade one at the local school.

Suggestions for discussions:

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2. Roles of different health care providers with this case.
3. Ethical dilemmas.
4. Patient's adherence to plan of care.
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7. Any conflict.

Brittany Hendle
Case Study
Developed by Wilma Jelley,
Physiotherapist, University of Ottawa

Brittany Hendle is 11 years old and was admitted through emergency with pain (10/10) in the right hip on weight bearing and all movements. Her mother, reports that the pain had began gradually about one month ago and became more severe with time. Initially, the pain was only present at night or after chores or playing soccer or volleyball. Brittany has one brother 6 years old and she lives on a dairy farm 20 minutes outside town. The patient's maternal grandmother and paternal grandfather have a history of colon cancer.

On examination a mass can be felt in the tissue at the proximal end of the right femur. Brittany is admitted and is awaiting a CT scan tomorrow morning and blood work.

Medications: Demerol

Suggestions for discussions:

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2. Roles of different health care providers with this case
3. Ethical dilemmas.
4. Patient's adherence to the plan of care.
5. Social / cultural issues.
6. Effect of cognitive issues
7. Any conflict.

Amélie
Case Study
Developed by Brigitte Johnstone, Physiotherapist, University of Ottawa

Amélie is a 14 year old girl who was ATVing with her cousin on her uncle's farm. Both were wearing helmets. They were travelling fast; hit a rock and both flew off the ATV. The girl was found unconscious. They were brought to the local community hospital. Amélie sustained a closed head injury with brain haemorrhage and a L3 spinal fracture with resulting paraplegia. She also had facial and rib fractures. The cousin sustained significant bruising, but no serious trauma. The two patients were stabilized, and the girl was airlifted to C.H.E.O. and admitted to I.C.U.

Amélie comes from a family on social assistance with 4 siblings. They live in a mobile home outside of the rural village.

Three months after the accident, Amélie is stabilized and returned to the local hospital, as it is easier for the family. Amélie is a paraplegic and has severe memory problems. She has no retrograde amnesia, but is unable to remember current situations. She has been prescribed anti-seizure medication and non-narcotic analgesics for pain.

Amélie is in hospital awaiting adaptations to the family home and community resources to be finalized.

Suggestions for discussions:

1. Patient's needs.
2. Roles of different health care providers with this case.
3. Ethical dilemmas.
4. Patient's adherence to plan of care.
5. Social / cultural issues.
6. Effect of cognitive issues.
7. Any conflict.

Mr. Gagnon
Case Study
Developed by Denise Dominey, Speech language pathologist & Lynn Campbell
RN, Nurse manager; Renfrew Victoria Hospital

Mr. Gagnon is a 62 year old bachelor who suffered a left CVA resulting it right hemiplegia, apraxia and aphasia. He has been on the continuing care unit for several weeks receiving physiotherapy and speech and language intervention in addition to nursing assistance with ADLs. His medical condition is now stable. He wants to go home but the team is concerned that he wouldn't be safe living alone. He is adamant about going home. He has support from a close friend who lives next door. He has other friends in town that can help out too. He has been out overnight on LOA with his friends to the hunt camp and is convinced he can manage at home.

MEDICAL HISTORY:

- CVA with right hemiparesis 6 years ago resulting in very little use of the right leg and arm.
- Diabetic
- Coronary Artery Disease
- Cardiogenic shock and subsequent transfer to Ottawa, where he had intensive medical management and intubation – had revasucularization by a PTCA and stenting of his circumflex artery
- MRSA positive – requiring Isolation

MEDICATIONS:

- ASA 81 mg P.O. OD
- METOPROLOL 12.5 mg P.O. OD
- PLAVIX 75 mg P.O. OD
- LIPITOR 80 mg P.O. OD
- PANTOLOC 40 mg P.O. OD
- ALDACTONE 25 mg P.O. OD
- RAMIPRIL 5 mg P.O. at H.S.
- COUMADIN 1 mg P.O. OD
- LASIX 40 mg P.O. BID

After much discussion with Mike and his friends, it is agreed that he will go to a rehab facility in Ottawa. His future living arrangements will be dependent on his outcomes after rehab.

After 10 weeks at the rehab facility, Mike returned to the local hospital with the following report.

MOBILITY:

- Able to walk approx. 300 feet with a quad cane.
- Wheelchair dependent for long distances.

ADL STATUS:

- Able to perform self care tasks, when set up by staff.
- Not able to perform housekeeping tasks or prepare meals.
- Displays good insight and judgment
- Important note: His home has been previously modified due to the CVA 6 years ago, i.e. grab bars in the bathroom; living area and bed and bath rooms all on one level.

SPEECH & LANGUAGE STATUS:

- Comprehension of spoken language shows a mild-moderate impairment.
- Difficulty with abstract concepts and 3+ step instructions.
- Relatively good comprehension of every day conversation.
- Able to read single words and short, simple sentences.
- Expressive language is moderately impaired.
- Able to relay his basic needs through gestures, speech and facial expressions.
- Able to express his preferences through choice making and can relay his opinions regarding future plans if his conversational partner uses close ended questions (e.g., yes/no).
- Uses phrases and short sentences functionally but there is still an apraxic component to his speech which impacts on speech clarity.
- Has word-finding difficulty and sometimes perseverates on certain phrases (e.g., 'things to do').

Mr. Gagnon continues to insist that he will go home and not to a nursing home.

Suggestions for discussions:

1. Patient's needs.
2. Roles of different health care providers with this case
3. Ethical dilemmas.
4. Patient's adherence to the plan of care.
5. Social / cultural issues.
6. Effect of cognitive issues
7. Any conflict.