Interprofessional Case Study 002

Name: Jane Doe Gender: Female Age: 60 Race: Hispanic

Allergies: sulfa (rash), contrast dye (hives), tape (rash) ht 157 cm, wt 50 kg

PMH: HTN (hypertension), hyperlipidemia, bilateral knee osteoarthritis, depression and anxiety, moderate dementia

Social History: Widowed and retired homemaker. Non-English speaking. Non-smoker and does not use alcohol. Up until a year ago she lived with her husband who assisted her with her medications and ADLs (activities of daily living) due to dementia. She currently resides with her son (a busy school teacher and athletic coach) and daughter in law (homemaker who does not speak Spanish) in their home. She uses a rolling walker to ambulate and her caregiver (daughter in law) reports she spends most of the day watching television.

Medications: aspirin 81 mg daily, Lipitor 10 mg daily, Diovan 160 mg daily, fluoxetine 20 mg, acetaminophen prn pain

Ms. Doe was brought to the ED three days ago by her daughter in law due to confusion, lethargy and a fever, 101 degrees. The daughter in law reported that Jane had been exceptionally confused and lethargic for the past four days. She continually groaned and rubbed her lower jaw. She also reported that the patient had several episodes of incontinence associated with this confusion. She would have taken her to a physician sooner but they were still in the process of filling out the “disability” paperwork for her. Jane was previously covered on her husband’s insurance. The daughter in law reported that she had to give her extra-strength Tylenol every two hours to help with her pain. Jane was admitted to the hospital’s general care floor and has been treated with antibiotics for a urinary tract infection for three days. The son continually reports to the nursing staff that his mother complains of a “toothache”. With treatment, Jane is more coherent, the fever has resolved, and urine cultures are now negative, though her white blood cell count is still slightly elevated at 11.