Life Care Plan

Prepared for:

Sandra Kirkline

(edited for example use)

Completed By: R Gordon Medical-Legal Services
4774 Carter Rd
Fairport, NY 14450

Client Information

Client:	Sandra Kirkline
Pre-evaluation contact:	10/19/02
Date of Evaluation:	10/24/02
Date Report initiated:	11/20/02
Date Report Finalized:	12/08/02

Sandra Kline is a 59 year old female who was referred for an evaluation by her attorney, Reginald Patton. The purpose of the evaluation is to assess the extent of the handicapping conditions that occurred following the motor vehicle accident of 5/28/01. And how these handicapping conditions impede her ability to live independently and handle all activities of daily living.

Demographic Information

Client Name:	Sandra Kirkline
Social Security Number:	123-45-6789
Date of Birth:	12/19/42
Age:	59
Date of Injury:	5/28/01
Sex:	Female
Race:	Caucasian
Marital Status:	Divorced
Address:	100 N. Amiston Ave. Claremont, NH 03743
County:	Sullivan
Closest Metro Area:	Concord approx 40 min.
Phone:	555-555-5555
Birthplace:	Silver City, NV
Citizen:	Yes
Elementary/Secondary Education:	Nevada
Employer at Time of Injury:	Boston Enterprises
Position:	Office Manager
Bilingual:	No
Glasses:	Reading
Dominant Hand:	Right
Height:	5' 7"
Weight (present):	150#

Weight (pre-injury): 175-180#

Initial Diagnosis and CPT Codes

S/P Motor Vehicle Collision with Roll-Over

Large Left Epidural Hematoma	853.00
Severe Closed Head Injury with Coma	854.00
Acute Respiratory Failure	518.81
Hypokalemia	276.8
Hyperglycemia	251.2
C2 Lateral Mass Fracture	805.00
Left Temporal Bone Fracture	959.01
Right Ear Laceration	873.x
Leukocytosis	288.60
Protein Calorie Malnutrition	260.
Anemia	285.9
Hypernatremia	276.0
Constipation	564.0
MRSA	V09.0
Atelectasis	770.4
Hypoxia	799.02
History of Hypertension	458.9
History of Thyroidectomy	244.1

Narrative Report

History

This interview took place in the home of her daughter Adeline, where Sandra currently resides. The residence is in Claremont, NH. Sandra's daughter, Adeline was present during the interview.

Adeline states that she was notified of the accident approximately 1 hour after it occurred, and arrived at the hospital approximately two and one half hours later. Adeline stated "it is my understanding that she suffered dual hematomas on either side of the parietal area. She had bruising of the brain, and that bruised area of the brain was removed, and this has affected the parietal region, affecting her ability to communicate. Post the surgery she had head swelling and diffuse brain injury, resulting in injury to the entire brain. She was really never expected to be able to respond at all."

Loss of Consciousness: Yes

Length of Unconsciousness or altered Mental Status: Four Months

Independent Recall: Sandra is nonverbal

Sandra was the driver involved in a roll-over motor vehicle accident on May 28, 2001. Sandra was unconscious and unresponsive at the scene. Sandra was taken to Pioneer Bay Medical Center. Sandra was admitted from 5/28/01-6-26-01, for the stabilization and evaluation of her injuries.

Sandra was transferred to Chelsea Collins Health Center, respiratory unit, from 6/26/01-10/20/01. Sandra on admission was a Rancho Los Amigos Level II (reaction is inconsistent and non-purposeful). The purpose of the admission to the respiratory unit was for tracheostomy care, and rehabilitative services. During this admission Sandra received respiratory services as well as occupational therapy (OT), physical therapy (PT), and speech therapy (ST). Adeline states that these services were discontinued when it did not appear that Sandra was making any progress. Frequently Adeline found her mother lying in "pee and poop". Adeline also purchased a geri-chair for her mother to assure that Sandra would be out of bed daily. Adeline states that Sandra was not well cared for at Chelsea Collins Health Center.

Adeline had the necessary structural changes made to her home to be able to care for her mother. Sandra was taken to Adeline's home on 10/20/01 for care.

On 12/30/01 Sandra was found during the night holding the bed rail, drooling, shaking from head to toe. Sandra was taken to Taggert Regional Medical Center for evaluation and treatment and discharged the following day.

Sandra returned to Adeline's home until 1/7/02.

Sandra was then admitted to Center for Life TBI Rehabilitation from 1/7/02-1/28/02, for a comprehensive rehabilitation plan. The long term goals included removal of tracheostomy, progression of an oral diet, and training the daughters to manage the care of their disabled mother. During this program Sandra also developed contractures of the

LUE. A series of casting and splinting were used to assist with stretching with good results Sandra was discharged to Adeline's home on 1/28/02.
Sandra did receive outpatient PT, OT, and ST through Taggert Regional Medical Center from approximately 1/02-8/02. Sandra received PT twice a week for 3 months, and OT twice a week for two months, then once a week until the insurance company stated they would need to see significant strides in recovery for therapies to be provided. Adeline states that ST was dropped after the evaluation due to lack of consistent participation. The speech therapist indicated that Sandra did not respond rapidly enough, and would not benefit from further treatment. Adeline stated that one of the consulting neurologist recommended that Sandra should be evaluated for an augmentative communication device. Adeline is sure that her mother needs further therapy with therapists that are trained to work with people this disabled. The only therapy Sandra is currently receiving is passive range of motion (ROM) by Adeline. Adeline stated that the family has no van to transport Sandra, so there is no way to seek appropriate therapy.

Prior to this accident Sandra was a single parent with two adult daughters. She was employed as an office manager, and was dedicated to her job. Socially she was active, although she preferred to spend time with her family.

Sandra's past medical history included: Hashimoto thyroiditis that required her to have her thyroid removed, and a hysterectomy in her 30's. Sandra also had a brief period of depression following her separation from her husband in 1999.

Chief Complaints

Disabling problems as defined and described by client/family history and reports. No physical examination occurred.

Sandra is a 59 year old female who is confined between a bed and a geri-chair in her daughter's home. Sandra currently is non-verbal, and non-ambulatory. Sandra has nystagmus in which both eyes move back and forth. Even with this eye movement Sandra can occasionally track movement with her eyes. Sandra is in a reclining geri- chair with her left arm contracted. While being observed Sandra raises her right arm above her head and straightens her arm on request. She consistently uses one finger to communicate "Yes" and two fingers to communicate "No." Sandra's communication is fairly consistent, but not always correct. She will relax both of her arms and her right leg upon request. Both of her feet and ankles are hyperextended, but both can be brought to a neutral position with passive ROM. Sandra's left arm is most seriously flexed toward her chest and her fingers are curled. Sandra can begin to relax them on request, but Adeline must assist. Adeline states that this is not always consistent. Adeline states that Sandra has a very small area of skin broken down on her sacrum. And Sandra's legs have atrophied since the accident.
She does get headaches from time to time, and because she cannot speak, I can only assume they are migraine because her eyes get all red and you can tell it really, really hurts.. You can also ask her if her head hurts and she will indicate yes by holding one finger up on her right hand. Sandra is also able to communicate pain and discomfort with

the movement of her right leg. When Sandra is in bed she is able to assist with turning, holding herself over to the side.

Sandra's care is monitored and provided for primarily by Adeline. Adeline has a schedule that is followed on a daily basis: Adeline gets up between 7:30-8:00 am and Sandra is turned and changed, then she will fall back asleep until about 9:00 am. She is given a bed bath every day and shampoo every other day. She eats breakfast in bed. Around 9:00-10:00 am she has a bath and between 10:00 am and 11:30 am she has breakfast. Next, she will sleep until 1:00 pm, is then taken out of bed and at 2:00 pm she has lunch, usually outside unless the temperatures are high She is able to open her mouth during meals. Sandra is able to eat soft food and drink from a glass during the day, when sitting up.. Around 3:00-3:30 pm, if she has not been outside, she may go outside for a walk. Around 6:00 pm she is ready to go back to bed. During the day, Adeline tries to get her mother to draw letters or numbers on a dry erase board, but her response is inconsistent. By 7:00 pm she is typically asleep. Around 8:00 pm she is supplemented with Ensure or Boost Plus, around 9:30-10:00 pm she is given her medication via the tube and turned. This is repeated again at 2:00 am and between 5:00-6:00 am.
Adeline does have the support of a nursing assistant's 24 hours per week.

Sandra had one seizure in 12/2001 and has been medicated with Dilantin since. Sandra also takes Zanaflex to help with spasticity. Sandra has needed to increase the dosage slowly.

Adeline feels that if her mother was in a structured environment, sensitive to the needs of a brain injured person, she would do better in terms of therapy, although without having the ability to transport Sandra to appointments the opportunities have been limited to what Adeline can provide. Adeline now has her mom eating soft foods, rather than puréed foods. Adeline can only do so much in the therapy area and she needs help. Adeline herself is disabled from Psoriatic Arthritis (see description below). She did inquire about the services provided by Knotty Pines in Kennebunkport, which is several hundred miles from their current home. It has both post acute rehabilitation and long-term supported living facilities. She is unsure whether or not they could take Sandra, given her current level of functioning.

Psychosocial Issues

Client: Sandra is non-verbal. Sandra communicates emotionally with an occasionally pout, or by moving her right leg rapidly back and forth. Sandra is also able to answer yes and no to questions using one finger as "yes" and two fingers as "no". Sandra uses these consistently, although not always correctly.

Family: "You don't have enough patience or pages to take this impact on me down. "My mom is not here anymore. It is like I lost my mother in that accident. I miss her. I love the mother I have but I miss the mother I lost." Adeline states that she feels she has lost her

mother in the accident. Adeline is concerned that if she moves her mother to another care facility her mother will feel rejected.
Adeline is also disabled with psoriatic arthritis, a degenerative condition, and has had multiple surgeries. Psoriatic arthritis is a systemic rheumatic disease, that primarily affects the skin and joints, but it can also cause inflammation in body tissues away from the joints other than the skin, such as in the eyes, heart, lungs, and kidneys. “I've had the left hip replaced twice, a right knee replacement, and a right wrist fusion." She does not know her own prognosis.
Adeline is having a very difficult time taking care of her mother.
Adeline’s daughter Jessica believes that her grandmother has wrecked her life.
Guardianship has been granted to Adeline and her sister.

Physical limitations

Loss of tactile sensation: Sandra’s family states that she has a loss of sensation bilaterally of the upper extremities. When asked to open her mouth wider when we are eating, she will sometimes do that. She will raise her hand and one finger for 'yes,' two fingers for 'no' fairly correctly; but sometimes she does not. If she is caught on an off moment, that system does not always work. Today I asked her if she wanted to get her hair washed, and she motioned for 'yes.' I asked where her hair was and where my hair was and she responded correctly both times, but when I asked her where her eyes were, she did not respond."

Reach: Sandra is able to reach for a glass, or food. Sandra is occasionally able to brush her hair. Adeline states that Sandra has left sided hemiplegia.

Lift: Sandra is able to assist in feeding herself, when in the mood.

Prehensile/grip: Sandra is able to hold up a mirror, occasionally. Sandra can also hold herself over in bed during bed bath.

Sitting: Sandra is able to sit in a reclining wheelchair for up to 5 hours per day. Sandra requires a harness when in the wheelchair.

Standing: Not functional

Walking/gait: Not functional

Bend/twist: Not functional

Kneel: Not functional

Stoop/squat: Not functional

Climb: Not functional

Balance: Not functional, poor balance

Breathing: No shortness of breath. Tracheostomy discontinued 1/02 at the Center for Life TBI Rehabilitation

Headaches: She does get headaches from time to time, and because she cannot speak, I can only assume they are migraine because her eyes get all red and you can tell it really, really hurts. Currently Adeline feels these occur 1-2 times a week, but Adeline has not needed to medicate Sandra for these.

Vision: "Mom has nystagmus where the eyes rapidly move back and forth. In the last two months, she has been able to focus a bit better more often, but the nystagmus is still there. She does put her glasses on, and it seems her nystagmus is slowed when she wears the glasses.

Hearing: Appears to be intact

Driving: Not functional

Physical stamina: Sandra fatigues easily
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Environmental Influences
Challenges to heat
Noisy environments
Sandra is uncomfortable in social situations

Additional Data
Emotional expression
"Sandra does not cry or smile, but she does pout her lips when she is bothered. Sandra can kick out her right leg to express pain

Current Medical Care
Dr. Harold Spitz (internist)
Dr. Jason Miller (physiatrist)
Dr. Caroline Davies (neurology)

Education and Training
Sandra graduated form Robinson Junior College.

Vocational History
Sandra had been working as an office manager of an eight employee company.
On weekends she would work for helping hands as a certified nursing assistant.

Behavioral Observations
Sandra was able to raise her right arm over her head and straighten her arm on request. She consistently uses one finger to communicate "yes" and two to communicate "no". Sandra is able to relax both of her arms and her right leg upon request.
Alert and aware of the presences, but not oriented times 3.
Sandra does not appear to understand the purpose or reason for the evaluation

Tests administered
None

Medical Summary
Sandra is a 59 year old female who was the driver in a multiple roll-over motor vehicle accident. Sandra was found at the scene unresponsive and posturing. Sandra was immediately taken to Pioneer Bay Medical Center.
On examination Sandra was found to have a large hematoma, 12-15 cm., on her left forehead extending to the left parietal scalp, with active bleeding. There was no movement of her extremities to pain. Glasgow coma scale was 3. CT of the abdomen and pelvis showed gastric distention and bibasilar posterior lung density. CT of the head showed a large left epidural hematoma and a small right subdural hematoma. CT of the spine revealed C2 lateral mass fracture.
Following trauma evaluation, she was intubated, and a right subclavian triple lumen catheter was placed. She underwent evacuation of the left epidural hematoma and right subdural hematoma. She remained in a cervical collar for the lateral C2 mass fracture. Her Glasgow coma scale remained a 3. She did have a gag reflex.
A Plastic Surgeon was consulted for her right ear laceration. She was continued on antibiotics while her intracranial pressure monitor was placed.
On 6/2/01, the intracranial pressure monitor was discontinued, after pressure returned to normal. The antibiotic, Ancef, was also discontinued. That evening she spiked a fever and her triple lumen catheter was changed over a guide wire and cultures were obtained.
On 6/3/01, she was started on 18-hour tube feeding for Dilantin dosing. Incision and drainage of her right ear hematoma with evacuation was done.
On 6/4/01, she underwent a tracheostomy and PEG tube placement. Glasgow coma scale was 4, cough, corneal, and gag reflex. CT of her head showed that the left hemisphere was improved and there was no extra-axial blood. The right hemisphere revealed a frontal, temporal, and parietal hypodensity along with intracranial hemorrhage in the right frontal lobe, all consistent with evolving contusions and some areas of possible necrosis. There was a 5 to 7 mm. right-to-left shift noted.
On 6/5/01 Sandra underwent a bronchoscopy.
Neurologically, Sandra would extend her arms in decerebrate to sternal rub; however, she would not follow any commands or track with her eyes. Over the next couple of days, she did however begin to open her eyes with turning and deep suctioning. PT, OT, and ST were seeing her, and they would occasionally get her to open her eyes. Over the next week, she remained the same and was awaiting a bed at Chelsea Collins Health Center.

That weekend she began to spike a fever and sputum culture revealed MRSA. She was placed on IV Ancef with good result.
She was transferred to Chelsea Collins due to the need for a full-time respiratory therapist. She was placed on intermittent positive pressure breathing treatments to improve her bibasilar atelectasis in lieu of her poor cough and expectorate efforts. Discharge instructions included TEDS to bilateral LEs, Multi-Podus boots to bilateral LEs, abdominal binder to protect PEG as needed, and Aspen collar at all times.

On 6/26/01 Sandra was admitted to Chelsea Collins Health Center respiratory unit, for care of her tracheostomy and rehabilitation therapy. Sandra received PT, OT and ST during her admission. Occasionally Sandra was able to visually tract movement. During this admission Sandra was nutritionally sustained by tube feedings with osmolite. On 10/20/01 Sandra was discharged to her daughter's home for long term care. Sandra was to be followed by Centrex Home Health Care and Caring Solutions.

Sandra remained in the care of her daughter, Adeline until 12/30/01, when Sandra was found during the night having an episode of unresponsiveness accompanied by shaking, and drooling. Sandra was taken to Taggart Regional Medical Center for evaluation.

Sandra was evaluated at Taggart Medical Center for possible seizure activity for 24 hours. Sandra received an EEG, CT Scan and started on Dilantin. (Documentation states that Sandra was started on Dilantin 6/3/01 at Pioneer Bay Medical Center. There is no further documentation when the Dilantin was discontinued prior to this event.)

Sandra returned to their home until 1/7/02, when she was admitted to Center for Life TBI Rehabilitation Facility, where she remained until 1/28/02. The admission to Center for Life TBI Rehabilitation was for a comprehensive rehabilitation plan. The goals were to remove the tracheostomy and progress to an oral diet. These goals were accomplished. Sandra's daughters received training to better manage their mother's disability.
Sandra was discharged home with her daughter Adeline.

Adeline states Sandra participated in outpatient rehabilitation through Taggart Regional Medical Center from approximately 1/02 through 8/02 (records not received). She received PT, OT, and ST. ST was discontinued after the evaluation because she could not consistently participate in the exercises. Sandra received PT services twice each week for three months. She had OT twice each week for two months, continued services once a week until the insurance company stated they would have to see significant strides in recovery for therapies to be provided. The therapists were unable to move her on to the next level, because of insurance restrictions. Currently passive ROM is completed by her daughter, Adeline.

Conclusions

Careful consideration has been taken to review the medical, psychosocial, and rehabilitative records contained in these files. Sandra remains overtly brain injured and multiply impaired, secondary to the motor vehicle accident and subsequent onset of disability of 5/28/01. Sandra is not able to participate in any part of independent living skills, and it is anticipated that she will remain this way for the remainder of her life. Sandra will require long term care either in a facility or at home with the assistance of home care services. Both alternatives have been outlined in the Life Care Plan, attached as appendix A.

Continued efforts should be made to work with Sandra to develop skills in communication and activities of daily living

If discharge is to home education and counseling will be needed to provide an effective home program. Due to Adeline's health care needs possibly a day care program may be an alternative to enhance Sandra socialization, provide a place for therapies, skilled nursing care, and a brief respite for the family.

The Life Care Plan, attached as Appendix A discusses all the needs dictated by the onset of Sandra's disabilities throughout the remainder of her life expectancy.

After you have had the opportunity to review this narrative report and the attached appendices, please do not hesitate to contact me should you have any further questions.

Respectfully Submitted,

Rebecca Gordon RN, CLNC, LCP
R. Gordon Medical-Legal Services