**Instructions**:

\*\*The following case studies are meant to help you practice clinical problem solving for clients with heart conditions in typical situations you might see them. I am assuming you are doing a full data collection. Please do not detail any plans or findings UNRELATED TO THE COURSE MATERIAL (I.e. related to her CV condition in some way). The case studies are to give you context, but keep your answers relevant to the course. You will have lots of chances in the real world to put it all together. : )\*\*

**Case study # 1 : Olga**

**Referral from physician at discharge from geriatric institute: “Please assess and treat decreased strength, endurance, and home safety secondary to deconditioning post-hospitalization.”**

**These are the initial results of the data collection you received from the physio:**

**Diagnosis**: 92-year-old female deconditioned post-hospitalization (for urosepsis and fall of unknown etiology).

**Setting:** home care. Lives in a private seniors residence alone with one cat. Dining room on main floor. Takes 1 meal per day in the dining room and eats breakfast and lunch in her apartment.

 **HPI:** Pt hospitalized due to sepsis and fall. History surrounding fall is fuzzy, pt cannot remember what happened, she was walking, and then woke up on the floor. She could not get up on her own because of decreased knee mobility and strength. Neighbour heard “thud” from the fall and called the building manager who helped her up and called her son. She seemed unwell/confused, so her son was worried she was concussed, and brought her to the hospital where she was dx with delirium and urosepsis. The CT scan of her head was clear. Spent 2 weeks in acute care, now d/c home with CLSC services because no care services are available in her residence. Saw cardiologist, dx with cardiac syncope, meds were adjusted (stopped bisoprolol), but pt. not scheduled for further follow up.

**Meds:** LANCORA™ (*ivabradine*); actonel; enalapril; Ceftriaxone

**Past medical history**: Congestive heart failure. Osteoporosis with hx of L4 fracture 5 years ago. Chronic back pain. Right knee OA. Anxiety.

**Baseline functional status:** Indep with cane inside apartment building, assistance from daughter for outings (usually would take wheelchair, became too SOB walking longer distances)

**Subjective:** ℅ generalized weakness, SOB on minimal exertion, and sleeps with HOB slightly elevated; lying flat makes her “perdre le souffle”. Occasional cough, hx of frequent “dizzy spells”.

**Objective:**  Resting vitals: 105/75, 75bpm, 97%, RR:14

Thin/frail appearance, but good colour, mild non-pitting oedema bilateral lower extremities. Skin: intact, shiny & pale, trophic changes to mid-calf (dry, thin skin, dec hair growth). No SOB observed at rest or during subjective exam. **Mobility:** ROM WFL except limitation Right knee flexion 90 degrees. Moderate valgus @ right knee. **Strength:** Generally 3-3+ L/E’s. U/Es generally ⅘. Balance: BERG 50/56, slight decreased ability on SLS tasks due to R knee OA, but quite functional. **TTE:** Max 90m with break standing to lean on wall and “catch her breath”, using std rollator walker. BORG 8/10, limiting factors dyspnea and general fatigue : “feeling like her legs will give way”. VS post-ambulation: 100/76, 83bpm, 93%, RR 20

**Relevant information:**

**What more do you want to know about her history of present illness?**

**Questions:**

1. What is the category? Justify your answer with relevant info from the case
2. What, if anything, is missing from the chart review and subjective section of the data collection WITH REGARDS TO HER CARDIOVASCULAR CONDITION? What else would you ask the patient or family (or the hospital) prior to continuing?
3. Is there any other objective data you would like to collect RELATED TO HER CARDIOVASCULAR CONDITION?
4. Why does this lady become short of breath when she lies down? How will this affect your treatment?
5. What will you monitor for SUBJECTIVELY during exercise considering her heart history? List 3 elements, ranked in order of importance. Be SPECIFIC and justify your answers.

1. What will you monitor for OBJECTIVELY during exercise? List 3 elements, ranked in order of importance. Justify each briefly by indicating what abnormal findings for each item may indicate considering her history.
2. How will you set initial training parameters? Do calculations using covered methods and chosen intensity. Does your answer make sense?
3. Set one endurance related functional smart goal.
4. How will you educate your patient regarding exercise?