PATIENT CHART

Chart for Jenny Brown Simulation #1

Download the following tools and attach to chart:

* Suicide Risk Assessment Guide

<https://www.mentalhealth.va.gov/docs/VA029AssessmentGuide.pdf>

* Primary Care PTSD Screen for DSM-5

<https://www.ptsd.va.gov/professional/assessment/documents/pc-ptsd5-screen.pdf>

* 3 Question DVBIC TBI Screening Tool

<https://www.mirecc.va.gov/docs/visn6/5_TBI_3_Question_Screening_Tool.pdf>

Although the nursing role does not involve establishing a diagnosis, the nurse should notify a licensed independent provider of the findings of any positive screen and take precautions to protect the safety of the patient.

SBAR Report Students Will Receive Before Simulation

**Time:** 0700, 2 days after admission to short stay acute psychiatric unit

**Person providing report:** Nurse going off duty

**Situation:** Jenny Brown is 29 years old, admitted two days ago for acute agitation and anxiety. She is 18 weeks pregnant with her first baby. She was voluntarily admitted from the Emergency Department where she was taken following an episode of acute agitation after ultrasound in the hospital’s Imaging Services Department. She received several doses of IV haloperidol in the ED before being transferred to our unit.

**Background:** While she was in Imaging for a routine ultrasound, Jenny had to be restrained. Apparently she became extremely agitated when the perinatologist told her that the fetus, a girl, has a cleft lip and palate. She was transferred to the Emergency Department and given three 2 mg doses of IV haloperidol over approximately 4 hours. Her suicide assessment was negative but she doubted her ability to safely care for herself at home and she agreed to admission for evaluation. On the first day of admission, she received 2 mg oral haloperidol regularly, every 4 hours. Yesterday she only had two doses and seemed much more stable. She still had difficulty sleeping and woke screaming from nightmares the first night. Last night she refused the haloperidol and slept on and off but there were no nightmares.

**Assessment:** Vital signs: T: 98.6, Pulse: 76, regular; Respirations: 16, BP: 112/74. Admitting diagnosis was panic attack with underlying generalized anxiety disorder and possible PTSD. She has no psychotic behaviors and is well oriented X3. Her prenatal admission assessment was done per protocol and everything looks good. Fetal heart rate is in the 130s. She’s also had the full psychiatric intake exam. Last night she slept poorly. She cries from time to time and is worried about her baby. Her vital signs have been stable. She has suicide checks ordered every 12 hours but so far those are all negative. She says she won’t harm herself because of the baby. She has showered and is well groomed with a normal train of thought and full vocabulary. She maintains eye contact when speaking. She has rapid, pressured speech at times. She is sometimes fidgety when seated and paces to calm herself. She’s been talking on the phone with her boyfriend from time to time all night – this seems to help calm her.

**Recommendation:** There will be a care conference later today to plan for discharge and follow-up care. The team is asking for three additional assessment to be done: a suicide risk assessment, PTSD assessment and a TBI screen. The forms are on the chart.

Provider Orders

**Allergies/Sensitivities:** None known

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Tuesday 2000 | **Acute Mental Status Change Admission Orders****Admit to Acute Short Stay Psychiatric Unit** **Service: Psychiatry** **Condition of patient:** Good1. **DIET:** Regular diet as tolerated
2. **VITAL SIGNS:** Every 4 hours with fetal heart rate check; notify MD for Temp above 101.5, HR>120, decline in neuro status, absence of FHT
3. **ACTIVITY:** As tolerated
4. **SAFETY CHECKS:** Every 2 hours for first 24 hours, then every 4 hours
5. **LABS:** Basic metabolic panel, urinalysis, hemoglobin & hematocrit
6. **MEDICATIONS:**
	1. Haloperidol 2 mg PO every 4 hours prn agitation, anxiety; may repeat in 2 hours prn severe anxiety- notify physician
	2. Haloperidol 5 mg IV for severe agitation – notify physician
	3. Prenatal vitamin X 1 po daily in am
	4. Acetaminophen 650 mg every 6 hours prn headache
7. **IV ORDER:** If need to start IV to administer medication, leave saline lock in place
8. **MISCELLANEOUS:** When patient is stable, complete assessment forms for PTSD, TBI, and suicide in preparation for team conference Thursday afternoon.
9. **REFERRAL:** Pediatric surgeon to visit patient before discharge

Marianne Hough, MD |

Stat Order Form

|  |  |
| --- | --- |
| **Date/Time:** | **STAT PHYSICIAN ORDER** |
| Tuesday 1500 | Haloperidol 2 mg IV stat. Repeat every 2-4 hours prn for up to 4 doses.Katherine Shannon, MD |

Lab Data

**(Sunday 1600)**

|  |  |  |
| --- | --- | --- |
| **Hematology** | **Result** | **Reference Range** |
| HGB (Hemoglobin) | 14 | 12.0-15.6 g/dL (F)13.0-18.0 g/dL (M) |
| HCT (Hematocrit) | 44% | 36-46 % (F)40-52 % (M) |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Sodium | 137 | 135-145 mmol/L |
| Potassium | 4 | 3.5-5 mmol/L |
| Carbon dioxide | 40 | 35-45 mm hg |
| Calcium | 2 | 2-2.6 mmol/L |
| Chloride | 103 | 95-105 mEq/L |
| Glucose | 105 | 65-110 mg/dL |
| Bun | 1.9 | 1.2-3 mmol/L |
| Creatinine | 1.0 | 0.8-1.3 mg/dL |

|  |  |  |
| --- | --- | --- |
| **Urinalysis** | **Result** | **Reference Range** |
| Color | Yellow | Yellow- dark yellow |
| Appearance | Clear | Clear |
| Specific gravity | 1.019 | 1.016-1.022 |
| pH | 5 | 5-6 |
| Glucose | Neg | Neg |
| Ketones | Neg | Neg |
| Leukocyte esterase | Neg | Neg |
| Nitrites | Neg | Neg |

Medication Administration Record

Scheduled & Routine Drugs

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Hours of Administration:** | **Date of Administration:** | **Initials** |
|  | Prenatal vitamin  |  |  |  | 0900 | * Wednesday / 0900
 | * *AC*
 |

PRN and STAT Medications

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | **Initials** |
|  | Haloperidol  | 2 mg | po | Every 4 hours prn agitation, anxiety | * Tuesday
* Wednesday
* Wednesday
 | * 2200
* 0200
* 0600
 | * *TJF*
* *TJF*
* *TJF*
 |
|  | Haloperidol  | 5 mg | IV | for severe agitation. Notify provider |  |  |  |
|  | Haloperidol  | 2 mg | IV stat | Repeat every 2-4 hours prn for up to 4 doses | * Tuesday
* Tuesday
* Tuesday
 | * 1600
* 1800
* 2000
 | * *RR*
* *RR*
* *RR*
 |
|  | Acetaminophen | 650 mg |  | Every 6 hours prn headache |  |  |  |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| *TJF* | Teresa Franklin, RN | *AC* | Angela Corbo, RN |
| *RR* | Richard Reid, RN |  |  |

Medical Reconciliation Form

**Source of medication list (i.e., patient, family member, primary care provider):** Patient, Jenny Brown

**Allergies/Sensitivities:** None known

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Frequency** | **Reason** | **Last Dose** | **Continue/DC** |
| Prenatal vitamins | 1 tab | PO | Daily |  | Tuesday AM | [x]  C [ ]  DC |
|  Acetaminophen | 650 mg | PO | PRN Headache |  | N/A | [x]  C [ ]  DC |

|  |
| --- |
| Signature RN: Richard Reid RN Print name: Richard Reid, RN Date: Tuesday, 1700  |

Scan to pharmacy