PATIENT CHART

Chart for Judy Jones Simulation #1

Download the following tools and attach to chart:

* The Confusion Assessment Method (CAM)

<https://hign.org/consultgeri/try-this-series/confusion-assessment-method-cam>

* Mental Status Assessment of Older Adults: The Mini-Cog™

<https://hign.org/consultgeri/try-this-series/mental-status-assessment-older-adults-mini-cog>

SBAR Report Students Will Receive Before Simulation

**Current time:** 1900 (day 2 of hospitalization)

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

**Situation:** Judy Jones is an 85-year-old female patient of Dr. Annette Parks who was admitted yesterday afternoon with a diagnosis of community-acquired pneumonia. She is being treated with IV levofloxacin and IV fluids.

**Background:** Judy Jones has a medical history of cervical spondylosis with pain controlled with acetaminophen when needed, hyperlipidemia that is controlled by diet. She has a history of carpal syndrome and had surgery on both wrists. She also has minor neurocognitive disorder due to Alzheimer’s disease. Her daughter tells us that for the past 2 years she has been forgetful, but oriented to all spheres.

**Assessment:** She is alert and oriented to person but needs frequent reorientation to place and time and is forgetful. At 1600 her vital signs were temp 99.9, heart rate 103, respirations 24, BP 130/68, pulse ox 95% on 2 liters of O2 via nasal cannula. Her heart rhythm is regular. Her IV of D5 .45 NSS running at 42 mL/hr is infusing well into her left forearm.

She frequently removes her nasal cannula, and when she does, her pulse ox goes down as low as 90%. Upon auscultation she has rhonchi bilaterally and occasional wheezing. There are PRN respiratory treatments ordered to relieve her wheezing. We are encouraging her to use the incentive spirometer every hour.

Ms. Jones is on a regular diet; her appetite is poor. Her abdomen is soft with bowel sounds present. Her last bowel movement was two days ago. She has been urinating without difficulty in the bathroom, but needs assistance getting into the bathroom, basically to manage the IV pole. Her skin looks great. I didn’t see any areas of breakdown, but she is at risk for skin breakdown because she is spending a lot of time in bed.

**Recommendation:** I recommend checking on her frequently due to the forgetfulness and to be sure she keeps her nasal cannula on. It is important that we continually assess her respiratory status. Her last albuterol treatment was at 1200, and she can have her next one whenever she needs it. Be sure to remind and reteach her each time how to use the incentive spirometer; she forgets. Please do a CAM assessment and don’t forget we are starting our new quality improvement project today. We are doing Mini-Cog assessments twice a week on each patient that scored a 3 or more on the Family Questionnaire for Dementia. See if you can do the Mini-Cog assessment on Ms. Jones before the end of your shift.

Provider Orders

**Allergies/Sensitivities:** Sulfa

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Tuesday 1500 | **Admit to Medical-Surgical Unit**  **Service: Medical Team B/Dr. Annette Parks**  **Condition of patient:** Good  **Code Status:** Full Code   1. **DIET:** Regular diet as tolerated 2. **VITAL SIGNS:** Every 4 hours with pulse oximetry. Call MD if less than 92% 3. **ACTIVITY:** Bed rest with bathroom privileges 4. **TESTS:** 5. X-ray daily 6. Repeat blood chemistry and hematology on Thursday 7. **THERAPY:** 8. Oxygen, 2 liters via nasal cannula 9. Incentive spirometry 10 times every hour while awake 10. **FLUIDS:** 11. D5.45 NSS @42 mL/hr 12. Monitor intake and output 13. **MEDICATIONS:**     1. Donepezil 10 mg PO at bedtime     2. Levofloxacin 500 mg IV every day     3. Acetaminophen 650 mg PO every 4-6 hours PRN neck pain     4. Albuterol 2.5 mg via nebulizer every 4 hours PRN for wheezing   Annette Parks, MD |

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Wednesday 0700 | 1. **ACTIVITY:** OOB ad lib 2. Discontinue I&O   Annette Parks, MD |

Lab Data

|  |  |  |
| --- | --- | --- |
| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC (White Blood Count) | 14 | 6.0-11.0 K/uL |
| RBC (Red Blood Count) | 5.2 | 4.5-5.9 M/uL |
| HGB (Hemoglobin) | 13 | 12.0-15.6 g/dL (F)  13.0-18.0 g/dL (M) |
| HCT (Hematocrit) | 48% | 36-46 % (F)  40-52 % (M) |
| PLT (Platelets) | 320 | 150-450 K/uL |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Sodium | 147 | 135-145 mmol/L |
| Potassium | 4 | 3.5-5 mmol/L |
| Carbon dioxide | 38 | 35-45 mm hg |
| Calcium | 2 | 2-2.6 mmol/L |
| Chloride | 98 | 95-105 mEq/L |
| Glucose | 200 | 65-110 mg/dL |
| BUN | 1.5 | 1.2-3 mmol/L |
| Creatinine | 1.0 | 0.8-1.3 mg/dL |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Day/ Time** | **ORAL** | **TUBE**  **FEED** | **IV** | **IVPB** | **OTHER** | **URINE** | **EMESIS** | **NG** | **Drains**  **Type:** | **Other** |
| DAY 1  11-7  7-3  3-11 | 475 |  | 436 |  |  | 650 |  |  |  |  |
|  | **Total Intake this shift:** 911 | | | | | **Total Output this shift**: 650 | | | | |

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Day/ Time** | **ORAL** | **TUBE**  **FEED** | **IV** | **IVPB** | **OTHER** | **URINE** | **EMESIS** | **NG** | **Drains**  **Type:** | **Other** |
| DAY 2  11-7  7-3  3-11 | 50 |  | 400 |  |  | 260 |  |  |  |  |
|  | **Total Intake this shift:** I & O discontinued by Dr. Parks at 0700 | | | | | **Total Output this shift**: | | | | |

Medication Administration Record

Scheduled & Routine Drugs

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Hours of Administration:** | **Date of Administration:** | **Initials** |
|  | Donepazil | 10 mg | PO | at bedtime | 2100 | * Tuesday | *TJF* |
|  | Levofloxacin | 500 mg | IV | every day | 1600 | * Tuesday * Wednesday | *TJF*  *LS* |
|  |  |  |  |  |  |  |  |

PRN Medications

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency**  **:** | **Date/Time Administered:** | | **Initials** |
|  | Acetaminophen | 650 mg | PO | every 4-6 hours PRN for neck pain | 2200 | * Tuesday | *TJF* |
|  | Albuterol | 2.5 mg | via nebulizer | Every 4 hours PRN for wheezing | 1600  2000  2400  0400  0800  1200 | * Tuesday/ * Tuesday * Wednesday * Wednesday * Wednesday * Wednesday | *TJF*  *TJF*  *RR*  *RR*  *LS*  *LS* |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| *TJF* | Teresa Franklin, RN | *LC* | Lisa Sousa, RN |
| *RR* | Richard Reid, RN |  |  |

BEST TOOLS:

Family Questionnaire *iii*

Please answer the following questions. This information will help us provide better care for your family member or friend. Thinking back over the past six months, before hospitalization, would you say your family member or friend has experienced or had problems with any of the following?

Please circle the answer.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 1. Repeating or asking the same thing over and over. | Not at all | Sometimes | Frequently | N/A |
| 2. Forgetting appointments, family occasions, holidays? | Not at all | Sometimes | Frequently | N/A |
| 3. Writing checks, paying bills, balancing the checkbook? | Not at all | Sometimes | Frequently | N/A |
| 4. Shopping independently for clothing or groceries? | Not at all | Sometimes | Frequently | N/A |
| 5. Taking medications according to instructions? | Not at all | Sometimes | Frequently | N/A |
| 6. Getting lost while walking or driving in familiar places? | Not at all | Sometimes | Frequently | N/A |
| 7. Making decisions that arise in everyday living? | Not at all | Sometimes | Frequently | N/A |

Relationship to patient \_Judy Jones - daughter\_(*spouse, son, daughter, brother, sister, grandchild, friend, etc.*)

This information will be given to the patient’s primary health care provider. Thank you for your help.

How to Use the Family Questionnaire:

If a family member or friend is with the patient, tell the patient you have a few questions for his or her family member or friend that will help you find out if

the patient has trouble remembering or thinking clearly. Explain that this information may not come to the hospital’s attention unless you ask about it and

that the information will help you take better care of the patient. Show the questionnaire to the patient if he or she asks to see it. Ask the patient for their

consent, then hand the questionnaire to the family member or friend. Once it is completed, score the questionnaire, and attach it to the patient’s chart.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Scoring:** |  |  |
|  | Not at all or N/A | = 0 |  |
|  | Sometimes | = 1 |  |
|  | Frequently | = 2 | **Total Score:** \_\_7\_\_ |

Score Interpretation: *A score of 3 or more should prompt further assessment. A score of 3-6 indicates possible dementia. A score of 7-10 indicates probable dementia.*

Adapted from a family questionnaire developed for the Chronic Care Networks for Alzheimer's Disease project, a joint project of the Alzheimer's Association and the National Chronic Care Consortium.

**Patient Behavior Triggers for Clinical Staff** *iv*

Individuals with undiagnosed dementia may exhibit behaviors or symptoms that offer a clue to the presence of dementia, for example, if the patient:

* Seems disoriented
* Is a “*poor historian*”
* Defers to a family member to answer questions directed to the patient
* Repeatedly and apparently unintentionally fails to follow instructions
* Has difficulty finding the right words or uses inappropriate or incomprehensible words
* Has difficulty following conversations

**How to use the patient behavior triggers:**

These triggers can be used on a laminated card or other convenient form to remind staff of signs and symptoms that indicate a need for dementia assessment.

Adapted from a similar tool developed for the Chronic Care Networks for Alzheimer's Disease project, a joint project of the Alzheimer's Association and the National Chronic Care Consortium.

When the results of any of these approaches indicate possible dementia, further assessment is needed to measure the level of cognitive impairment and

identify delirium, depression, and other conditions that can cause cognitive impairment. For assessment instruments that are useful for this purpose, see

*Try This:* Mental Status Assessment for Older Adults: The Mini Cog; *Try This:* Confusion Assessment Method (CAM); *Try This:* Brief Evaluation of Executive Dysfunction; and *Try This:* The Geriatric Depression Scale (GDS), all available at https://consultgeri.org/tools/try-this-series.

