PATIENT CHART

Chart for Judy Jones Simulation #2

Download the following tool and attach to chart:

* 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

**Time:** 2100 Thursday (day 3 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 with a diagnosis of community-acquired pneumonia. We are currently treating her with IV antibiotics and respiratory treatments.

**Background:** Ms. Jones has a medical history of cervical spondylosis - she takes acetaminophen for pain as needed, and hyperlipidemia that is controlled by diet. She has minor neurocognitive impairment due to Alzheimer’s disease manifested by short-term memory issues, and sequencing and executive functioning deficits. During the day she is easily redirected, but earlier tonight was much more confused. She went into the employee refrigerator and took two sandwiches back to her room and ate a little of each. Then she proceeded to take out her saline lock and placed it like a toothpick in one of the sandwiches. The resident on call doubled her dose of lorazapem to 2mg. She is sleeping now.

**Assessment:** Ms. Jones is alert and oriented to self. She needs to be reoriented often to place and time. She is confused. Her vital signs at 2000 were temp 99.2, HR 96 and rhythm regular. RR was 24, BP 128/62. Pulse ox was 95% on 2 liters of oxygen via nasal cannula. She frequently removes her cannula, and when she takes it off I have seen her pulse oximetry go as low as 90%. Upon auscultation she has rhonchi bilaterally and occasional wheezing. There are PRN respiratory treatments if she is wheezing. We are encouraging her to use the incentive spirometer every hour.

She is on a regular diet, and her appetite is good. Her abdomen is soft with positive bowel sounds; she had a bowel movement today.

Judy has been ambulating to the bathroom and urinating without difficulty. Her gait is steady. She forgets to reapply her nasal cannula when she gets back into bed after ambulating. Her skin looks good; there are no areas of breakdown. She has a saline lock in her left hand.

**Recommendation:** I would recommend checking on her frequently due to her confusion and removing of the oxygen. It is important that we continually assess her respiratory status and encourage the incentive spirometry; her last albuterol treatment was at 1830.

When you go to assess Ms. Jones, she will need her saline lock flushed and her Mini-Cog assessment completed. I was unable to do the Mini-Cog on her because she was asleep when I went back to reassess her after the lorazepam.

Provider’s 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. Check 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. 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 if wheezing   Annette Parks, MD |

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

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Thursday 0700 | 1. Discontinue IV Fluids 2. Insert saline lock. Flush with 3mL NSS every 8 hours   Annette Parks, MD |

Stat Order Form

|  |  |
| --- | --- |
| **Date/Time:** | **STAT PHYSICIAN ORDER** |
| Wednesday/ 0800 | Lorazapam 1 mg PO now  Annette Parks, MD |
| Thursday/ 1900 | Lorazapam 2 mg PO now  Avery James, MD |

Lab Data

**(on admission: Tuesday)**

|  |  |  |
| --- | --- | --- |
| **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 mEqL |
| Glucose | 200 | 65-110 mg/dL |
| BUN | 1.5 | 1.2-3 mmol/L |
| Creatinine | 1.0 | 0.8-1.3 mg/dL |

Lab Data

**(Thursday: day 3)**

|  |  |  |
| --- | --- | --- |
| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC (White Blood Count) | 12 | 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) | 37% | 36-46 % (F)  40-52 % (M) |
| PLT (Platelets) | 320 | 150-450 K/uL |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Sodium | 140 | 135-145 mmol/L |
| Potassium | 4.5 | 3.5-5 mmol/L |
| Carbon dioxide | 38 | 35-45 mm hg |
| Calcium | 2 | 2-2.6 mmol/L |
| Chloride | 100 | 95-105 mEq/L |
| Glucose | 196 | 65-110 mg/dL |
| BUN | 1.3 | 1.2-3 mmol/L |
| Creatinine | 0.9 | 0.8-1.3 mg/dL |

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 * Wednesday * Thursday | *TJF*  *RR*  *TJF* |
|  | Levofloxacin | 500 mg | IV | every day | 1600 | * Tuesday * Wednesday * Thursday | *TJF*  *LS*  *TJF* |
|  | Heplock Flush | 3mL NSS |  | every 8h | 2400  0800  1600 |  |  |

PRN and STAT Medications

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | | **Initials** |
|  | Acetaminophen | 650 mg | PO | Every 4-6 hours PRN neck pain | 2200  0630  1300 | * Tuesday * Wednesday * Thursday | *TJF*  *RR*  *LS* |
|  | Albuterol | 2.5 mg | via nebulizer | Every 4 hours PRN wheezing | 1600  200  2400  0400  0800  1200  0600  1200  1830 | * Tuesday * Tuesday * Wednesday * Wednesday * Wednesday * Wednesday * Thursday * Thursday * Thursday | *TJF*  *TJF*  *RR*  *RR*  *LS*  *LS*  *RR*  *LS*  *TJF* |
|  | Lorazapam | 1 mg | PO |  | 0800 | * Wednesday | *LS* |
|  | Lorazapam | 2 mg | PO |  | 2000 | * Thursday | *TJF* |

Nurse Signatures

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

Intravenous Fluid Administration Record

Continuous IV Fluids

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **IV Fluid:** | **Rate:** | **Site:** | **Volume:** | **Date/Time Hung and Initials:** | **Discontinued Date/Time and Initials:** |
|  | D5 .45 NSS  bag #1 | 42 mL/hr | Left forearm | 1000 mL | * Tuesday/ 1600 *TJF* | * Tuesday/ 1545 *LS* |
|  | D5.45 NSS  Bag #2 | 42 mL/hr | Left forearm | 1000 mL | * Wednesday/ 1545 *LS* | * Wednesday/ 1930 *RR* |

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:**

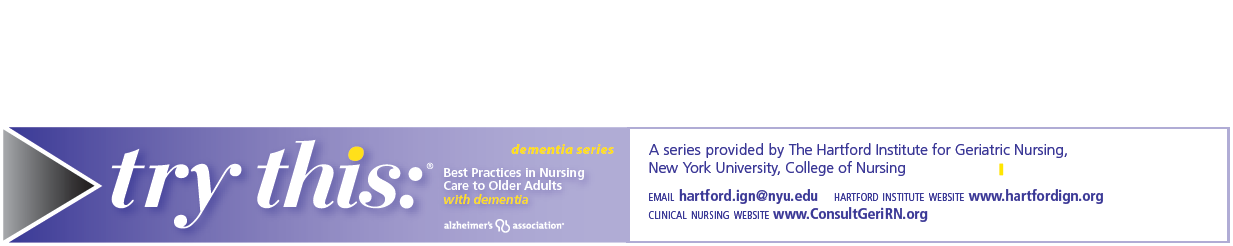
These triggers can be used on a laminated card or other convenient form to remind staff of signs and symptoms that indicate a need for dementia assessment.

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.



**Judy's clock drawing showing a clock face. Numbers 6 and 12 are missing on the face. Numbers are not exactly aligned with their clock position. Two hands of equal length point toward 11 and an indistinguishable number.**

Mini Cog on Day 2

Could not recall 3 words

Positive screen for dementia