PATIENT CHART

Chart for Damon McAdam Simulation #2

SBAR Report Students Will Receive Before Simulation

**Time:** 1500

**Person providing report:** Nurse ending shift

**Situation:** Damon McAdam is a2 ½ year old boy, admitted through the emergency department yesterday for acute gastroenteritis with dehydration and unusual bruising.

**Background:** Damon McAdam was brought to the ED last night after having vomiting and diarrhea for 3 days. Child was lethargic and refusing any type of oral intake. Since admission, he has received a 250 mL bolus of Lactated Ringers solution followed by a solution of 5% dextrose in ½ normal saline. His IV started at 60 mL/hour, and then was decreased to 20 mL/hour this morning. He refused oral fluids overnight but this morning drank 200 mL of water and 50 mL of juice and kept it down. He’s been eating graham crackers also. His last stool was around midnight and was small and liquid. He has had 3 wet diapers since 0200 for a total output of 500 mL. His last specific gravity was 1.008. His last vital signs were: temp 37, HR 110, respirations 28, BP 80/65. His poor skin turgor has improved and his mucus membranes are now pink and moist.

Damon is up-to-date on his immunizations and receives regular well-child visits. His mother is very concerned about Damon’s recent development of some unusual behaviors like flapping his hands and not responding to his family members, as well as a loss of some previous language skills. She states that her husband Marshall is becoming frustrated with Damon, though she is not sure how he got the bruises on his torso, and she has not felt that her children were ever unsafe with him. The ED social worker talked with Mom briefly last night. This morning the pediatric/family social worker spent some time with her. Marshall is coming in later this afternoon to meet with the social worker. Dr. Patel is coming in this afternoon and if dehydration is resolved, he plans to stop the IV fluids, meet with parents and social services, and probably discharge with developmental clinic follow-up and a home assessment. Dr. Patel brought up the possibility of autism with Mom and she became very upset.

**Assessment:** Damon had gastroenteritis with dehydration that is resolving. He has a developmental delay with a new diagnosis of possible autism which needs to be confirmed by the developmental specialist. Unusual bruises have raised the possibility of maltreatment requiring parental and home assessment.

**Recommendation:** Damon needs vital signs checked and a focused assessment for dehydration. Notify Dr. Patel of the results. Continue to assess his behavior and support his parents. There will be a meeting with Damon’s parents, Dr. Patel, and the social worker regarding discharge that you will need to attend later today.

|  |  |
| --- | --- |
| **Patient Name:** Damon McAdam | **MRN:** 1234567 |
| **Room: 520** | **Provider Name:** Dr. Patel/Peds Team |
| **DOB:** MM-DD-YYYY (reflect age 30 months) | **Date Admitted:** yesterday’s date |
| **Age:** 2 ½ | **Allergies:** None known |

Provider Orders

**Allergies/Sensitivities:** None known

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Day 1 | **Activity:** Activity as tolerated |
|  | **Diet:** Clear liquids, progress as tolerated |
|  | **Vital signs:** Every 4 hours |
|  | **Medications:** Acetaminophen 160 mg orally every 4-6 hours as needed for temp over 38.5 |
|  | **Intravenous fluids:** 5% Dextrose in 0.45% Sodium Chloride on pump at 60 mL/hour  **Intake and output,** assess every 4 hours |
|  | Consult with Social Services Department. Chandra Patel, MD |
|  |  |
| Day 2 | Decrease intravenous fluids to 20 ml/hour. Chandra Patel, MD |
|  |  |

Progress Notes

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| --- | --- |
| **Date/Time:** |  |
| Day 1 | Patient is a 2 ½ year old male who was admitted to the pediatric unit this evening from the Emergency Department. He began vomiting 4 days ago, and progressed to vomiting 6-8 times/day over the next 3 days. Diarrhea began 3 days ago, progressed to 10 episodes of runny green stools yesterday. Has refused food and fluids for past few days. Mother has tried over-the-counter oral rehydration solutions with no success. Damon had not voided for over 12 hours at the time of admission, and he had become lethargic. Mom states he was 31 lbs (14 kg) at the pediatrician’s office 2 months ago, he was 13.6 kg yesterday. ED staff also noted atypical bruising on patient’s trunk, as well as atypical behaviors and developmental delays. Will admit for IV rehydration and evaluation by child protective services. Chandra Patel, MD |
|  |  |
| Day 2 | Improvement noted in hydration status. Mucus membranes pink and moist, improved skin turgor, voiding 500 mL overnight. Had one liquid stool, no further vomiting. Taking fluids orally. Social Services consult ordered and both parents will meet with social worker this afternoon, county child protective services notified and will follow up. Mother has been attentive at bedside and father is home with 2 older children. Will decrease IV fluids to 20 mL/hour. Will tentatively plan discharge after consult with child protective service and in-house Social Services.  Chandra Patel, MD |
|  |  |

Nursing Notes

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| --- | --- |
| **Date/Time:** |  |
| Day 1 | Received 2 ½ year old male from ED for treatment of gastroenteritis requiring IV rehydration. 24g IV started in Emergency Department and bolus of 250 mL of Lactated Ringers administered. IV changed to 5% Dextrose in 0.45% Sodium Chloride on pump at 60 mL/hour. Mom remains at bedside. Patient is screaming and difficult to assess, calms with Mom’s interventions. Noted to have atypical bruising on trunk and also lack of recognizable words. Mom states language is delayed. Dr. Patel notified and has requested Social Service consult.  Robert Kelly, RN |
| Day 2 | 0800: Child slept most of night, Mom remained at bedside, slept some in chair. IV decreased to 20mL/hour. No vomiting, diarrhea episodes decreasing. He is taking some fluids, skin turgor improving, seems more active, and is voiding. No fever, no acetaminophen needed. Belinda Garcia, RN |

Medication Administration Record

Scheduled & Routine Drugs

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Hours of Administration:** | **Date of Administration:** | **Initials** |
| Xx/xx/xx  Day 1: Day of admission to Emergency Department | Intravenous fluids**:** 5% Dextrose in 0.45% Sodium Chloride on pump at 60 mL/hour | 60mL/hour | IV | Continuous | 2215 | xx | RK |
| Day 2  0800 | Intravenous fluids**:** 5% Dextrose in 0.45% Sodium Chloride on pump | decrease to 20mL/hour | IV | Continuous | 0800 | xx | BG |

PRN and STAT Medications

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | |
| Day 1 |  |  |  |  |  |  |
| Day 1 |  |  |  |  |  |  |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| RK | Robert Kelly, RN | BG | Belinda Garcia, RN |
|  |  |  |  |

Medication Reconciliation Form

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

**Allergies/Sensitivities:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Frequency** | **Reason** | **Last Dose** | **Continue/DC** |
| No home meds |  |  |  |  |  | C  DC |
|  |  |  |  |  |  | C  DC |
|  |  |  |  |  |  | C  DC |

|  |
| --- |
| Signature RN: Robert Kelly, RN  Print Name: Robert Kelly RN Date: xxxx |

Reviewed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewed by\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_

Scan to pharmacy

Vital Signs Record

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Day 1**  **yester day** | **Day 1**  **Yesterday** | **Day 2 Today** | **Day 2**  **Today** | **Day 2**  **Today** | **Day** | **Day** |
| **Time:** | 2000 | 2345 | 0330 | 0810 | 1230 |  |  |
| **Temperature:** | **38** | **37** | **37.2** | **37.2** | **37** |  |  |
| **Heart Rate/Pulse:** | 126 | 122 | 126 | 116 | 110 |  |  |
| **Respirations:** | 30 | 30 | 28 | 26 | 28 |  |  |
| **Blood Pressure** | 78/52 | 76/54 | 82/54 | 84/60 | 80/65 |  |  |
| **O2  Saturation:** | 97 | 96 | 96 | 99 | 98 |  |  |
| **Weight:** | 13.6kg |  |  | 13.8kg |  |  |  |
|  |  |  |  |  |  |  |  |
| **Nurse Initials:** | *RK* | *RK* | *BG* | *BG* | *BG* |  |  |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORAL**  **Day 1:-** Day of Admission to ER through 2400 | **TUBE**  **FEED** | **IV** | **IVPB** | **OTHER** | **URINE** | **EMESIS** | **NG** | **Drains**  **Type:** | **Other** |
| 30 mL |  | 250 mL Lactated Ringers bolus  180 mL 5% Dextrose 0.45% Sodium Chloride |  |  |  |  |  |  | Small liquid stool |
| **Total Intake this shift:** 460 mL | | | | | **Total Output this shift**: Trace stool | | | | |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORAL**  **Day 2**  **Pediatric Unit (0001-0800)** | **TUBE**  **FEED** | **IV** | **IVPB** | **OTHER** | **URINE**  **Day 2** | **EMESIS** | **NG** | **Drains**  **Type:** | **Other** |
| 250 mL |  | 480 mL 5% Dextrose 0.45% Sodium Chloride |  |  | 30  250  220 |  |  |  |  |
| **Total Intake this shift:** 730 mL | | | | | **Total Output this shift**: 500 mL | | | | |

Lab Data

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| --- | --- | --- |
| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC (White Blood Count) | 10.5 | 6.0-11.0 K/uL |
| RBC (Red Blood Count) | 5.8 | 4.5-5.9 M/uL |
| HGB (Hemoglobin) | 16.8 | 12.0-15.6 g/dL (F)  13.0-18.0 g/dL (M) |
| HCT (Hematocrit) | 50% | 36-46 % (F)  40-52 % (M) |
| PLT (Platelets) | 398 | 150-450 K/uL |

|  |  |  |
| --- | --- | --- |
| **Urinalysis** | **Result** | **Reference Range** |
| **Urine Specimen Type:** |  | |
| Color | Dark yellow | Yellow - dark yellow |
| Appearance | Clear | Clear |
| Specific gravity | 1.024 | 1.016-1.022  Higher values - may indicate dehydration |
| Bacteria | Absent | Absent |
| WBC | neg | Negative - trace |
| RBC | neg | Negative - trace |
| pH | 5.5 | 5-6 |
| Ketones | neg | Negative |
| Protein | neg | Negative |
| Glucose | 0 | 0-15 mg/dl |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Sodium | 146 | 135-145 mmol/L |
| Potassium | 4.9 | 3.5-5 mmol/L |
| Carbon dioxide | 44 | 35-45 mm hg |
| Calcium | 2.2 | 2-2.6 mmol/L |
| Chloride | 95 | 95-105 mEq/L |
| Glucose | 70 | 65-110 mg/dL |
| Bun | 1.4 | 1.2-3 mmol/L |
| Creatinine | 1.0 | 0.8-1.3 mg/dL |