PATIENT CHART

Chart for Henry Williams Simulation #2

Download these tools and attach to chart:

* The Modified Caregivers Strain Index: <https://hign.org/consultgeri/try-this-series/modified-caregiver-strain-index-mcsi>
* The Geriatric Depression Scale: <https://hign.org/consultgeri/try-this-series/geriatric-depression-scale-gds>

SBAR Report Students Will Receive Before Simulation

**Time:** 1500

**Person providing report:** Nurse ending shift

**Situation**: Henry Williams is an 80-year-old male who was admitted through the Emergency Department 5 days ago with an acute exacerbation of COPD. He is being transferred to a rehab facility today due to generalized weakness and slow progression with his pulmonary rehab.

**Background:** Mr.Williams has been living at home with his wife Ertha. Besides his COPD he has a history of cardiovascular disease and hearing loss. Since admission, he has received albuterol treatments and oral prednisone in addition to the medications he was previously taking at home. He has improved but still gets short of breath with his ADL’s. His wife Ertha is experiencing some dementia and Mr. Williams is her primary caregiver. He seems depressed and worried about her and how they will manage. Their daughter-in-law Betty has been caring for Ertha since Henry was hospitalized. After discharge from rehab, the plan is for them to move to an assisted living facility.

**Assessment:** Vital signs stable with oxygen saturation in low 90’s. He uses 2 liters per nasal cannula PRN at night and for shortness of breath with activity. Transfer forms have been faxed to the rehab facility. His AM meds were given and the rest are not due until 2000.

**Recommendation:** Check discharge orders and prepare for discharge to rehab facility. He needs vital signs and a focused assessment and completion of his medication reconciliation form. And please administer the Geriatric Depression Scale and Caregiver Strain Index before his family arrives. When the family arrives assess need for teaching about medications. Call the rehab facility and give them a report when you have completed all your assessments.

Provider Orders

**Allergies/Sensitivities:** Penicillin

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Admission | Bedrest, BRP with assist |
|  | Regular, low fat diet |
|  | Intake & output |
|  | Respiratory treatment:Albuterol nebulizer treatment 2.5 mg and ipratropium bromide 0.5 mg in 3 cc NS q 20 minutes x 3, followed by albuterol 2.5 mg and ipratropium bromide 0.5 mg in 3 cc NS q 2 hours (decrease frequency as tolerated) |
|  | Oxygen: per nasal cannula to maintain SaO2 at or above 90%. |
|  | Labs: CBC, ABG’s, BNP (brain natriuretic peptide) |
|  | IV: Lactated ringers @ 50 ml/hour |
|  | Prednisone 40 mg daily x 10 days |
|  | Fluticasone propionate 250 mcg & salmeterol 50 mcg oral inhaler q 12 hours |
|  | Albuterol 2 puffs as needed for acute onset of shortness of breath |
|  | Lisinopril 12.5 mg po daily |
|  | Metoprolol tartrate 50 mg po daily |
|  | Acetylsalicylic acid 81 mg po daily |
|  | Rosuvastatin calcium 20 mg every evening |
|  | Montelukast sodium 10 mg every evening. |
|  | Katherine Nelson, MD |
| Today | DC IV line. |
|  | Continue oral meds as ordered. |
|  | Discharge to rehab facility for pulmonary rehabilitation program |
|  | Katherine Nelson, MD |

Provider Progress Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Today | Mr. Williams has progressed; ready for discharge to rehabilitation facility. He requires oxygen at night and with activity. He should continue on all previous medications.Katherine Nelson, MD |

Nursing Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Today0700 | Patient states he “feels fine” this morning. He will be discharged to rehabilitation center today. Medication reconciliation form and other discharge forms need to be completed and faxed to the rehabilitation center. M. Hayes, RN |

Medication Administration Record

Scheduled & Routine Drugs

**Allergies/Sensitivities:** Penicillin

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Time/Date Administered** | **Initials** |
|  | Prednisone | 40 mg | PO | Once a day for 10 days | 0800 | 0830 | *TR* |
|  | Advair diskus | Fluticasone propionate 250 mcg/salmeterol 50 mcg | inhaler | Every 12 hours | 0800 | 0830 | *TR* |
|  | Lisinopril | 12.5 mg | PO | Once a day | 0800 | 0830 | *TR* |
|  | Metoprolol tartrate | 50 mg | PO | Once a day | 0800 | 0830 | *TR* |
|  | Acetylsalicylic acid | 81 mg | PO | Once a day | 0800 | 0830 | *TR* |
|  | Rosuvastatin calcium | 20 mg | PO | Every evening | 2000 |  |  |
|  | Montelukast sodium | 10 mg | PO | Every evening  | 2000 |  |  |

PRN and STAT Medications

**Allergies/Sensitivities:** Penicillin

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | **Initials** |
|  | Albuterol | 2 puffs | inhaler | as needed for acute onset of shortness of breath | 09001300 |  | *TR**TR* |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| *MH*  | Melanie Hayes, RN | *TR* | Todd Raymer, RN |
|  |  |  |  |

Vital Signs Record

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Admit** | **Day 1** | **Today** |  |  |  |
| **Time:** | 2200 | 0300 | 0740 |  |  |  |
| **Temperature:** | 98.4 | 98.0 | 98.2 |  |  |  |
| **Heart Rate/Pulse:** | 110 | 112 | 98 |  |  |  |
| **Respirations:** | 30 | 26 | 22 |  |  |  |
| **Blood Pressure** | 140/90 | 135/88 | 130/78 |  |  |  |
| **O2  Saturation:** | 82% | 88% | 90% |  |  |  |
|  |  |  |  |  |  |  |
| **Nurse Initials:** | *MR* | *MH* | TR |  |  |  |
|  |  |  |  |  |  |  |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORAL****Day 5** | **TUBE****FEED** | **IV** | **IVPB** | **OTHER** | **URINE****Day 5** | **EMESIS** | **NG** | **Drains****Type:** | **Other** |
| 220 mL |  | 380mL |  |  | 620mL |  |  |  |  |
| **Total Intake this shift:** 380 mL | **Total Output this shift**: 620 mL |

Lab Data

|  |  |  |
| --- | --- | --- |
| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC (White Blood Count) | 11.8 | 6.0-11.0 K/uL |
| RBC (Red Blood Count) | 4.7 | 4.5-5.9 M/uL |
| HGB (Hemoglobin) | 10 | 12.0-15.6 g/dL (F)13.0-18.0 g/dL (M) |
| HCT (Hematocrit) | 40% | 36-46 % (F)40-52 % (M) |
| PLT (Platelets) | 225 | 150-450 K/uL |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Sodium | 137 | 135-145 mmol/L |
| Potassium | 4.0 | 3.5-5 mmol/L |
| Carbon dioxide | 4.5 | 35-45 mm hg |
| Calcium | 2.2 | 2-2.6 mmol/L |
| Chloride | 96 | 95-105 mEq/L |
| Glucose | 109 | 65-110 mg/dL |
| Bun | 2.5 | 1.2-3 mmol/L |
| Creatinine | 1.2 | 0.8-1.3 mg/dL |

|  |  |  |
| --- | --- | --- |
| **Arterial Blood Gases** | **Result** | **Reference Range** |
| PH | 7.34 | 7.35-7.45 |
| PCO2 | 50 | 35-45 mmHg |
| PO2 | 88 | 75-100 mmHg |
| HCO3 | 27 | 22-26 mEq/L |
|  |  |  |

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** |
|  |  |  |  |  |  | [ ]  C [ ]  DC |
|  |  |  |  |  |  | [ ] C [ ]  DC |
|  |  |  |  |  |  | [ ] C [ ]  DC |
|  |  |  |  |  |  | [ ] C [ ]  DC |
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|  |  |  |  |  |  | [ ] C [ ]  DC |
|  |  |  |  |  |  | [ ] C [ ]  DC |

|  |
| --- |
| Signature RN: Print Name: Date:  |

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

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

Scan to pharmacy