PATIENT CHART

Jayla Wright Simulation #2

SBAR Report Students Will Receive Before Simulation

**Time:** 0700

**Person providing report:** Nurse

**Situation:** Jayla Wright is a 24-year-old woman of color. She fell exiting public transportation five days ago.

**Background:** Jayla fell five days ago exiting public transportation. She presents to the Emergency Department with a wound on her left upper thigh. She denies hitting her head or losing consciousness. She has been trying to care for her wound as she is reluctant to seek care. Her friends were insistent she seek medical attention when her wound started draining. The previous shift administered a Tetanus booster, as she could not recall her last dose.

**Assessment:** Jayla is alert and oriented. She has a wound present on her left upper thigh with purulent drainage. She does not have a primary care provider. Jayla denies taking medications.

**Recommendation:** Complete a wound assessment. Perform a dressing change per provider’s order. Administer medications per provider’s order. Discuss community resources for LGBTQ+.

Provider Orders

**Allergies/Sensitivities: NKDA**

|  |  |
| --- | --- |
| **Date/Time:** |  |
| xx/xx/xx | Assess wound q day while in the hospital. |
| xx/xx/xx | Clean dressing changes q day.  |

Progress Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
|  |  |
|  |  |
|  |  |

Nursing Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Xx/xx/xx0400  | Wound noted to upper left, midline thigh; large gauze dressing was removed and open to air for dressing change; purulent drainage noted. C. Cousins, RN |
| Xx/xx/xx0445 | Left upper, midline thigh wound measures 7cm X 5cm X 1cm; no tunneling noted. Purulent drainage noted; minimal peri-wound redness. Patient denies pain. Wound cleansed with sterile saline and applied ABD pad applied to wound. C. Cousins, RN |

Medication Administration Record

Scheduled & Routine Drugs:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Hours of Administration:** | **Date of administration:** | **Initials** |
| xx/xx/xx | Cefazolin | 1 gram | IV | q 6 hours |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

PRN and STAT Medications

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | **Initials** |
| xx/xx/xx | Acetaminophen | 500 mg | PO | PRN, q 6hours, as needed for temperature over 101 or pain 1-3/10 on pain scale |  |  |  |
|  |  |  |  |  |  |  |  |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| *CC* | *Carolyn Cousins* , RN |  |  |
|  |  |  |  |

Vital Signs Record

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date:** | xx/xx/xxxx | xx/xx/xxxx |  |  |  |  |
| **Time:** | 0400 | 0800 |  |  |  |  |
| **Temperature:** | 100.5 | 100.6 |  |  |  |  |
| **Heart Rate/Pulse:** | 92 | 95 |  |  |  |  |
| **Respirations:** | 18 | 18 |  |  |  |  |
| **Blood Pressure** | 140/84 | 138/84 |  |  |  |  |
| **O2  Saturation:** | 99% | 99% |  |  |  |  |
| **Weight:** | 135 stated per patient  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Nurse Initials:** | *CC* | *CC* |  |  |  |  |

Medication Reconciliation Form

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

**Allergies/Sensitivities: NKDA**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Frequency** | **Reason** | **Last Dose** | **Continue/DC** |
|  |  |  |  |  | X/XX/XX | [ ]  C [ ]  DC |
|  |  |  |  |  | X/XX/XX | [ ]  C [ ]  DC |
|  |  |  |  |  | X/XX/XX | [ ]  C [ ]  DC |
|  |  |  |  |  | X/XX/XX | [ ]  C [ ]  DC |

|  |
| --- |
| Signature RN: *Carolyn Cousins* Print Name: Carolyn Cousins, RN Date: xx/xx/xxxx |

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

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

Scan to pharmacy

Lab Data

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| --- | --- | --- |
| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC | 13.0 | 4.1-10.9x10 |
| RBC | 5.0 | 4.3-5.9x10 |
| HCT | 42 | 40-50% |
| HbG | 15 | 13.2-17.5 |
| PLT | 500 | 150-400x10 |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| BUN | 9 | 5-20 mg/dL |
| Ca | 9.1 | 8.5-10.2 mg/dL |
| CL | 100 | 98-107 mEq/L |
| NA | 136 | 134-144 mEq/L |
| K | 5.2 | 3.6-5.0 mEq/L |
| Glucose | 120 | 65-100 mg/dL |
| CO2 | 24 | 23-29 mEq/L |
| Creatinine | 0.9 | 0.6-1.2 mg/dL |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORAL** | **PO** | **IV** | **IVPB** | **OTHER** | **URINE** | **EMESIS** | **NG** | **Drains****Type:** | **Other** |
|  |  |  |  |  |  |  |  |  |  |
| **Total Intake this shift:**  | **Total Output this shift**: |