PATIENT CHART

Mike Walker Simulation #2

SBAR Report Students Will Receive Before Simulation

**Time:** 1930

**Person providing report:** Nurse on medical/surgical floor reporting to oncoming nurse

**Situation:** Mr. Mike Walker is a 70-year-old man admitted to us from the Emergency department, following heavy rectal bleeding.

**Background:** Mr. Walker was recently diagnosed with stage 4 colon cancer. He had been seen about 2 months ago for rectal bleeding and had subsequent testing completed, resulting in the recent diagnosis of stage 4 colon cancer. Today, he had an episode at home of heavy rectal bleeding, and came to the ED. After an intake, the patient went into the bathroom and had another bleeding episode, and upon return to his bay, his vital signs changed, and blood pressure dropped drastically. An IV was inserted and he received 1,000 mL of D/5 and NSS. His vital signs stabilized. He is currently on 02 @2 L/min and a second IV of D/5 and NSS is running.

**Assessment:** VS: Temp 98.8; Pulse-92; Resp-22; BP 104/78; SPO2 97%

Blood Work: Hg 6.8 grams/dL; Hematocrit 28 percent. Patient was type and cross matched for blood- patient is O negative. Because patient was bleeding an 18g IV cath was inserted in the ED. The patient and his spouse are very concerned about him getting blood. We did not have time for a detailed discussion.

**Recommendation:** Patient was admitted for observation and receipt of a unit of packed red blood. He was typed and cross matched in the ED; blood type is O negative. Also discuss the husband’s desire to provide blood for his spouse. We did provide all of the supplies that you will need for the transfusion, in the hopes that you can find a resolution. Please continue to observe him, monitor bleeding and vital signs.

Provider Orders

**Allergies/Sensitivities:** No Known Drug Allergies

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| **Date/Time:** |  |
| Day 1  20XX  1000 | IV IV1000 mL D5, 0.9% Nacl @ 100 mL/hour  Labs:   * Type and Screen for Packed red blood cells STAT * Complete Blood Count * Basic Metabolic Panel * Liver Function Tests * Kidney Function Tests   Taylor Burke, MD |
| Day 1  20XX  1200 | Admit to Medical Surgical Unit  Diagnosis: Stage 4 Colon Cancer; Rectal bleeding  Code Status: Full code  Allergies: No known drug allergies  Vital signs: q 4 hours, and as indicated during blood transfusion  Activity: Up as able. Monitor for dizziness r/t blood loss  Consent Form: needs to be signed for Transfusion of Blood Products  Nursing Orders:   * Transfuse with one unit of packed red blood cells * Sodium Chloride 0.9% 250 mL for 1 dose with blood transfusion * Hg and Hct in AM * Monitor I and O   Diet as tolerated  IV1000 mL D5, 0.9% Nacl @ 100 mL/hour  **Medications:**  Famotidine 10 mg daily  Acetaminophen 650 mg, Tab, PO, give prior to blood/blood product transfusion  Diphenhydramine 25 mg, Cap, PO, PRN, Routine, give prior to blood/blood product transfusion Taylor Burke, MD |

Progress Notes

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| **Date/Time:** |  |
| Day 1  20XX  1100 | Pt seen in ED. C/O rectal bleeding that has filled the toilet bowl during bowel movement, increased since last seen by MD. Has been receiving varied tests and was recently diagnosed with colon cancer.  **Review of systems (completed following stabilization of bleeding):**  HEENMT-  Head: Denies: headaches, head trauma  Eyes: Denies: eye pain or infections; wears glasses for reading and distance  Ears: Denies difficulty hearing, ear infection, discharge or dizziness  Nose: Denies runny or bloody nose  Mouth and Throat: Denies recent infection or other issues  Cardiovascular: was diagnosed with hypertension at age 52, took hydrochlorothiazide for about 10 years. Not taking antihypertensive medications now. Denies problems with varicose veins or temperature of legs/feet.  Thoracic: Denies: SOB, dyspnea, unless walking up 2 or more flights of steps; wheezing, sleeps with one pillow.  Gastrointestinal: Denies nausea, vomiting, diarrhea, constipation. Has occasional heartburn, takes 10 mg. Famotidine daily and calcium carbonate OTC as needed. Started to have rectal bleeding about 3 months ago, but it had gotten more frequent. Recently received many tests and diagnosed with stage 4 colon cancer. Bowel sounds active and present in 4 quadrants.  Genitourinary: Denies urinary frequency, burning.  Musculoskeletal: has some issues with discomfort in his knees when kneeling, States “related to getting older”.  Neurological: no history seizures, Denies numbness, tingling, dizziness, lightheadedness. Alert and oriented X3.  Previous surgeries:tonsillectomy at age 14 because of constant throat infections. Had an ankle repair due to a biking injury about 10 years ago.  Family history: Mother died of colon cancer at age 72; Father- died of a stroke, age 85. Grandparents- died of older age. Mother’s parents lived to in their 80s. Father parents lived to late 70’s.  Social History: Retired teacher. Divorced, one son, lives with partner.  **Physical Exam:**  **General**: Mr. Walker is a slightly obese man who looks his stated age of 70. He was in no distress at the time of this exam; he was sitting in bed, somewhat relaxed and easily communicating.  **Vital signs**: Blood pressure: BP 110/76 both arms supine Pulse 94 regular Respirations: 22 and regular, Temperature 98.98  **Weight**: 205 lbs.  **Skin**: pale, no lesions noted  **Head**: normocephalic, atraumatic  **Eyes:** Visual Acuity not tested. Visual fields full to confrontation, extra ocular movements (EOMs) intact, pupils are equal, round and reactive to light and accommodation (PERRLA), conjunctiva pink, no injection, sclerae not icteric, Fundus exam: discs sharp, no hemorrhages or exudates  **Ears**: Pinna normal, external canals normal. Tympanic membranes normal with good light reflex.  **Nose:** Mucosa pink, watery clear nasal discharge noted inferior turbinates appear normal  **Sinuses:** nontender over maxillary and frontal sinuses bilaterally  **Throat**: lips, buccal mucosa normal. Good dentition, no obvious caries, no gingival bleeding, tongue midline, uvula midline, gag reflex intact, tonsils absent  **Neck**: supple, no JVD, carotids 2+ without bruit, full range of motion, trachea midline and mobile, thyroid not enlarged or nodular, no lymphadenopathy  **Chest**: normal AP diameter, symmetrical expansion, normal tactile fremitus bilaterally, clear on percussion and auscultation. RR even. Lung sounds vesicular throughout lung fields. No wheezes, rales or rhonchi heard.  **Breasts**: normal male, no masses, gynecomastia or discharge  **Cardiovascular**: PMI located in the fifth intercostal space 2 cm lateral to midclavicular line. No RV heave. No thrill. S1 and S2 normal, no murmurs or rubs  **Abdomen:** abdomen rounded but not distended, normoactive bowel sounds, Abdomen soft. Liver span 8cm MCL, No tenderness, guarding or rebound, no abdominal bruit  **Rectal:** anal sphincter reddened, no hemorrhoids present, prostate normal size, no prostatic masses felt, no stool present in ampulla  **Genitalia**: normal circumcised male, testes normal consistency without masses, no penile discharge  **Lymphadenopathy**: No cervical, occipital, pre or post auricular, supraclavicular, axillary, epitrochlear nodes noted. No inguinal lymphadenopathy.  **Pulses**: femorals 2+, no bruit, Brachial, radial, dorsalis pedis 2+ bilaterally  **Musculoskeletal:** Normal range of motion of neck, shoulders, elbows, wrists. Good grip strength, Normal motion of hips, knees, ankles, feet. Tender over right lateral epicondyle. Range of motion of spine not tested  **Neurologic**: Oriented x3. Cranial nerves II to XII intact (I not tested), reflexes symmetric, 2+ biceps, triceps, brachioradialis; knees, ankles 1+. Sensation to pin and light touch normal. Cerebellar function normal. Gait not tested |

Nursing Notes

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| **Date/Time:** |  |
| XX/XX/20XX  1200 | Pt seen in ED. C/O rectal bleeding which has increased since last seen by MD. Stated that at home, he filled toilet with blood after bowel movement. Initial VS T98.4, P88, R 22; BP 130/88, SPO2 98%. Went to bathroom while in ED, filled toilet again with blood. Upon return to bay, patient became ashen, vital signs changed quickly P120, RR 28; BP 88/60 and then bottomed out, SPO2 86%. O2 applied at 6 L/min; IV started D5/NSS and 1,000 mL administered over 2 hours. VS stabilized. Second IV of IV 1,000 mL of D5/NSS running at 100mL/hr. Patricia Hampson, RN |

Vital Signs Record

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| **Date:** | **Day 1**  **20XX** | **Day 1**  **20XX** | **Day 1**  **20XX** | **Day 1**  **20XX** | **Day 1**  **20XX** |  |
| **Time:** | initial | 1 hour later | 30 mins after | 45 mins after | 60 mins after |  |
| **Temperature:** | 98.4 | - | 98.2 | 98.2 | 98.4 |  |
| **Heart Rate/Pulse:** | 88 | 120 | 100 | 98 | 96 |  |
| **Respirations:** | 22 | 28 | 24 | 22 | 22 |  |
| **Blood Pressure** | 130/88 | 88/60, then could not hear | 106/72 | 108/72 | 110/78 |  |
| **O2  Saturation:** | 98% | 86% | 95% | 95% | 96% |  |
| **Weight:** |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **Nurse Initials:** | *PH* | *PH* | *PH* | *PH* | *PH* |  |

Lab Data

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| **Complete Blood Count** | **Result** | **Reference Range** |
| Hemoglobin | **6.8 grams/dL (L)** | Male 13.2-17.3 g/dL;  Female- 11.7 – 15.5 g/dL |
| Hematocrit | **28 percent (L)** | Male: 39-50%  Female: 35 – 47% |
| Platelets | 156,000mc/L | 150,000 – 400,000 /mcL |
| RBC | **4.0 cells/mc/L (L)** | Male 4.5-5.7 cells/mcL  Female: 3.8--5.1 cells/mcL |
| WBC | 4,200 cells/mc/L | 4,000 - 11,000 cells/mcL |

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| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Glucose | 102 | 80-120 mg/dL |
| Carbon Dioxide (CO2) | 26 | 22-29 mmol/L |
| Electrolytes:  Sodium | 144 | 135-145 mmol/L |
| Potassium | 3.6 | 3.5-5.0 mmol/L |
| Chloride | 102 | 95-105 mmol/L |
| Magnesium | 2 | 1.5-3.0 mg/dL |
| Phosphorous | 3 | 2.0-4.5 mg/dL |
| Calcium | 10 | 8-12 mg/dL |

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| **Liver Function Tests** |  |  |
| ALT (SGPT) (Alanine aminotransferase) | **38 (H)** | 4-36 U/L |
| AST (SGOT) (Aspartate aminotransferase) | **129 (H)** | 30-120U/L |
| Bilirubin | 0.75 | 0-1.5 mg/dL |
| **Kidney Function Tests** |  |  |
| BUN (Blood Urea Nitrogen) | 12 | 8-120 mg/dL |
| Creatinine | 1.0 | 0.6-1.2 mg/dL |

Intake & Output Bedside Worksheet

**INTAKE Day 1 20XX OUTPUT Day 1 20XX**

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| **ORAL** | **PO** | **IV** | **IVPB** | **OTHER** | **URINE** | **EMESIS** | **NG** | **Drains**  **Type:** | **Other** |
|  |  | 1,000mL |  |  | 100 mL |  |  |  | Had a large bowel movement with bloody drainage |
| **Total Intake this shift:** 1,000mL | | | | | **Total Output this shift**: 100mL+ | | | | |