PATIENT CHART

Chart for Thomas Sykes Simulation #2

SBAR Report Students Will Receive Before Simulation

**Time:** 1500

**Person providing report:** Nurse completing day shift

**Situation:** 17-year-old male seen yesterday by his pediatric nurse practitioner (PNP) who determined that Thomas was a risk to himself and had him admitted for inpatient psychiatric evaluation.

**Background:** Thomas Sykes is a 17-year-old male who lives in an inner-city apartment with his sister Keisha and Keisha’s 3-year-old son, Torrey.Thomas’ father is not involved in his life and his mother passed away about 10 years ago from complications associated with uncontrolled diabetes and obesity. Following his Mother’s death, Thomas moved in with Keisha, and she became his legal guardian. About a year ago, Keisha, Thomas, and Torrey moved for Keisha’s new job in the local battery plant packaging batteries. Her shifts rotate between days and evenings, requiring Thomas to care for Torrey when Keisha has to work the evening shift.

Thomas has been overweight for most of his life, but over the past year he has gained 60 pounds and currently weighs 240 pounds. With a height of 5 feet, 11 inches, Thomas is obese, with a BMI of 33.5. Last year, Thomas was in his junior year of high school and had been planning to graduate with his classmates, so the move for Keisha’s work has been hard. Thomas has not made friends at his new school and spends most of his time alone playing video games or watching television with Torrey. He has also been skipping school up to three times a week and doesn’t want to leave the apartment.

Yesterday, Thomas was seen by the PNP and completed the Columbia-Suicide Severity Rating Scale. He identified suicide intent with a specific plan. He was admitted late yesterday and put on suicidal precautions. He is at his first group therapy meeting right now.

**Assessment:** Obesity and depression

**Recommendation:** He will be back from group in a minute or two. See how it went for him, assess his mood. His med just came up from pharmacy so please administer his escitalopram 10 mg.

|  |  |
| --- | --- |
| **Patient Name:** Thomas Sykes  | **MRN:** 764433 |
| **Room:** | **Provider Name:** Douglas Wright, MD |
| **DOB:** 05-22-YYYY (reflect age 17) | **Date Admitted:**  |
| **Age:** 17 years old | **Allergies:** None known |

Provider Orders

**Allergies/Sensitivities:** None known

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Day 1 | **Suicide Ideation Admission Orders****Admit to Pediatric Psychiatric Unit** **Service: Psychiatry** **Condition of patient:** Stable1. **NURSING**: Patient must have 1:1 nursing care until further notice
2. **DIET:** Regular diet as tolerated
3. **VITAL SIGNS:** Every 4 hours; notify MD for temp above 101.5
4. **ACTIVITY:** Suicide precautions
5. **SAFETY CHECKS:** Patient must have sitter at bedside at all times.
6. **LABS:** Complete blood count, basis metabolic panel, lipid panel
7. **MEDICATIONS:** Escitalopram 10 mg by mouth every day
8. **MISCELLANEOUS:** Complete suicide precautions checklist

Douglas Wright, MD |

Suicide Precautions Checklist

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| --- | --- |
| **PRIOR to patient arrival, please ensure the following are removed:** | Initials |
| \_x\_ Telephone\_x\_ Curtains\_x\_ Extra Chairs\_x\_ Sharps Container\_x\_ Hand Sanitizer\_x\_ Plastic Garbage Bags\_x\_ Extra BP Cuffs |  |
| **PRIOR to patient arrival, please:** |  |
| \_x\_ Call prn company to secure a bedside attendant\_x\_ Call Distribution for suicide cart and place outside of the room\_x\_ Lock all drawers that contain sharps and medications\_x\_ Replace plastic garbage bags with paper bags from Housekeeping |  |
| **UPON patient arrival, please:** |  |
| \_x\_ Ensure attendant is with patient at all times. At break times, ensure coverage for patient.\_x\_ Alert Nursing House Manager of patient’s arrival and condition.\_x\_ Notify Security of patient’s arrival and condition.\_x\_ Notify Dietary of suicide precautions. Check tray outside of room and remove any glassware or silverware. |  |

Person responsible for completing checklist:

Initials \_TS\_\_ Print Name: \_\_\_\_Tonya Smith\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_Tonya Smith\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Progress Notes

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| --- | --- |
| **Date/Time:** |  |
| Day 1 | Thomas is a 17-year-old male, referred from Dr. Henretty’s office for suicidal ideation and depression. His appearance suggests a history of depression alongside a reported weight gain over the past year of 60 pounds. His C-SSRS identified intent and a plan for suicide. Will place on suicide precautions and check patient and his belongings for weapons. Will begin group therapy tomorrow and will also start daily escitalopram 10 mg PO. Awaiting results from blood work. Douglas Wright, MD |
|  |  |

Nursing Notes

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| --- | --- |
| **Date/Time:** |  |
| Day 1 | Thomas was admitted today for suicidal ideation. He was placed on suicide precautions and will begin medication and group therapy tomorrow. He was checked for sharps and objects that could be used to injure himself both on person and in belongings. Vital signs are stable. His affect is flat and physically he is dirty and smells of body odor.Pat Farina, RN |
|  |  |

Medication Administration Record

Scheduled & Routine Drugs

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Hours of Administration:** | **Date of Administration:** | **Initials** |
| Xx/xx/xx | escitalopram | 10 mg | PO | QD | 1600 |  |  |

PRN and STAT Medications

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** |
| Day 1 | acetaminophen | 650 mg | PO | Q4H PRN |  |  |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| PF | Patricia Farina |  |  |
|  |  |  |  |

Medication Reconciliation Form

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

**Allergies/Sensitivities:** None known

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

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| --- |
| Signature RN: Patricia FarinaPrint Name: Patricia Farina, RN Date: Yesterday’s date: |

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

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

Scan to pharmacy

Vital Signs Record

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Day 1** | **Day**  | **Day** | **Day**  | **Day**  | **Day**  | **Day** |
| **Time:** | 1500 |  |  |  |  |  |  |
| **Temperature:** | 37.0 |  |  |  |  |  |  |
| **Heart Rate/Pulse:** | 76 |  |  |  |  |  |  |
| **Respirations:** | 18 |  |  |  |  |  |  |
| **Blood Pressure** | 132/81 |  |  |  |  |  |  |
| **O2  Saturation:** | 96% |  |  |  |  |  |  |
| **Weight:** | 240 pounds |  |  |  |  |  |  |
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| **Nurse Initials:** |  |  |  |  |  |  |  |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| ORALDay 1 | TUBEFEED | IV | IVPB | OTHER | URINEDay 1 | Emesis | NG | DrainsType: | Other |
| 1000 mL |  |  |  |  | X 4 |  |  |  |  |
| **Total Intake this shift:** 1000 mL | **Total Output this shift**: x 4 |

Lab Data

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| --- | --- | --- |
| **Complete Blood Count** | **Result** | **Reference Range** |
| WBC (White Blood Count) | 7.1 | 6.0-11.0 K/uL |
| RBC (Red Blood Count) | 5.2 | 4.5-5.9 M/uL |
| HGB (Hemoglobin) | 14.1 | 12.0-15.6 g/dL (F)13.0-18.0 g/dL (M) |
| HCT (Hematocrit) | 32.0 | 36-46 % (F)40-52 % (M) |
| PLT (Platelets)  | 321 | 150-450 K/uL |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel** | **Result** | **Reference Range** |
| Sodium | 138 | 135-145 mmol/L |
| Potassium | 3.9 | 3.5-5 mmol/L |
| Carbon dioxide | 38 | 35-45 mm hg |
| Calcium | 2.4 | 2-2.6 mmol/L |
| Chloride | 97 | 95-105 mEq/L |
| Glucose | 98 | 65-110 mg/dL |
| Bun | 1.5 | 1.2-3 mmol/L |
| Creatinine | 1.0 | 0.8-1.3 mg/dL |

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| --- | --- | --- |
| **Lipid Panel** | **Result** | **Reference Range** |
| Total cholesterol | 199 | < 200 normal |
| HDL | 46 | > 40 normal |
| LDL | 99 | < 100 normal |
| Triglycerides | 148 | < 150 normal |