PATIENT CHART

Chart for Thomas Sykes – Simulation #3

SBAR Report Students Will Receive Before Simulation

**Time:** 0900

**Person providing report:** Home care coordinator

**Situation:** 17-year-old male recently discharged from inpatient psychiatric facility for suicidal ideation, depression, and obesity. Now for home care evaluation of weight loss and depression.

**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. 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. 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 weighed 240 pounds on admission for inpatient treatment. 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 was hard for Thomas. He did not make friends at his new school and spent most of his time alone playing video games or watching television with Torrey. He began skipping school up to three times a week and did not want to leave the apartment.

Following an appointment with a pediatric nurse practitioner, Thomas was admitted to the inpatient psychiatric unit for evaluation for his suicidal ideation. He has undergone group therapy, individual therapy, and is on escitalopram. Upon discharge, he stated that counseling was helping and he was feeling less depressed. Before discharge, Thomas met with the nutritionist to establish an eating plan to help him get to a healthier weight. He is working on this healthy eating weight-loss plan and keeping a food log.

**Assessment:** Obesity and depression

**Recommendation:** During your visit, obtain current weight, review food journal, and evaluate how he is doing with his diet. Repeat the Columbia-Suicide Severity Rating Scale and compare it to the last one that was administered.

**HOME HEALTH AGENCY PLAN OF CARE**

**123 Main Street, Big City, USA 12345**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Health Insurance Claim #**123456789 A  | **Start of Care**XX/XX/XX | **Certification Period**XX/XX/XX – XX/XX/XX | **Medical Rec. #**727648 | **Provider #**45678789 |
|   |

|  |  |
| --- | --- |
| **Patient Name:** Thomas Sykes | **Provider:** Susan Henretty, DNP, CRNP, PPCNP-BC |
| **DOB:** 05/22/YYYY; **Age:** 17 | **Provider Address:** 1010 Western Ave. Big City, USA |
| **Address:** 12 Duracell Lane, Downtown | **Provider Phone:** 888-444-3333 |
| **Phone**: 577-666-7890 |  |

|  |
| --- |
|  |
| **Principal Diagnosis:** Depression |
| **Surgical Procedure:** NA |
| **Other Pertinent Diagnoses:** Obesity  |
| **Durable Medical Equipment & Supplies:**  **Safety Measures:**  |
| **Nutritional Requirements:** Low-fat diet **Allergies:** No known allergies |
| **Functional Limitations** ☐ Amputation ☐ Paralysis ☐ Legally blind ☐ Bowel/bladder ☐ Endurance☐ Dyspnea on exertion ☐ Incontinence ☐ Ambulation ☐ Contracture☐ Speech ☐ Hearing ☐ Other |
| **Activities Permitted:** ☐ Complete bedrest ☐ BR/BRP ☐ Bed to chair ☐ Up as tolerated**Assistive Devices**☐ Walker ☐ Cane ☐ Crutches ☐ Wheelchair |
| **Mental Status: X** Oriented ☐ Forgetful ☐ Disoriented ☐ Agitated ☐ Comatose ☐ Depressed ☐ Lethargic |
| **Prognosis:** ☐ Poor ☐ Guarded ☐ Fair **X** Good ☐ Excellent |
| **Orders for Discipline and Treatments (Specify Amount, Frequency, Duration)**Instruct about healthy nutrition with review of food log, hydration, medications |
| **Goals / Rehab Potential / Discharge Plan:**Weight reduction of 40 pounds and continued absence of suicidal ideation. Discharge to PNP after goals are met. |
| **Nurse’s Signature:** Rebecca Herrington, RN |

Provider Orders

**Allergies/Sensitivities:** None known

|  |  |
| --- | --- |
| **Date/Time:** |  |
| On discharge from hospital | RN home visit every 3 weeks (call for further visits)   |
|  | **Diet:** Low fat |
|  | **Weight:** Daily |
|  | **Vital Signs:** Per visit |
|  | **Medications:**  |
|  | escitalopram 10 mg by mouth every day |
|  | acetaminophen 650 mg by mouth every 8 hours as needed for pain |
|  |  |
|  | Assess medication compliance |
|  | Assess food log and provide healthy eating suggestions as needed |
|  | Assess exercise routine and suggestions for improvements where appropriate. |
|  | Notify PNP with weight gain > 2 pounds, noncompliance with medication, or any additional concerns. |
|  | Susan Henretty, DNP, CRNP, PPCNP-BC |

**COLUMBIA-SUICIDE SEVERITY RATING SCALE**

***Psychiatric Inpatient Setting – Discharge Screener***

(as completed in psychiatric inpatient unit)

| **Ask questions that are bold and underlined** | **Discharge** |
| --- | --- |
| **Ask Questions 1 and 2** | **YES** | **NO** |
| 1. **Wish to be Dead:**

Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.***While you were here in the hospital, have you wished you were dead or wished you could go to sleep and not wake up?*** | **X** |  |
| 1. **Suicidal Thoughts:**

General non-specific thoughts of wanting to end one’s life/die by suicide, “*I’ve thought about killing myself”* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***While you were here in the hospital, have you actually had thoughts about killing yourself?***  | **X** |  |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6** |
| **3) Suicidal Thoughts with Method (without specific plan or intent to act):** Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*” ***Have you been thinking about how you might kill yourself?***  |  | **X** |
| **4) Suicidal Intent (without specific plan):** Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to “*I have the thoughts but I definitely will not do anything about them*.” ***Have you had these thoughts and had some intention of acting on them or do you have some intention of acting on them after you leave the hospital?***  |  | **X** |
| **5) Suicide Intent with Specific Plan:** Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself either for while you were here in the hospital or for after you leave the hospital? Do you intend to carry out this plan?***  |  | **X** |
| **6) Suicide Behavior*****While you were here in the hospital, have you done anything, started to do anything, or prepared to do anything to end your life?***Examples: Took pills, cut yourself, tried to hang yourself, took out pills but didn’t swallow any because you changed your mind or someone took them from you, collected pills, secured a means of obtaining a gun, gave away valuables, wrote a will or suicide note, etc. |  | **X** |

*NOTE: At time of original publication, this scale was available at http://cssrs.columbia.edu/documents/inpatient-discharge-screener/. It is no longer available online*

**COLUMBIA-SUICIDE SEVERITY RATING SCALE**

*Screening Version – Since Last Contact*

| **SUICIDE IDEATION DEFINITIONS AND PROMPTS** | **Since Last Contact** |
| --- | --- |
| **Ask questions that are bold and underlined**  | **YES** | **NO** |
| **Ask Questions 1 and 2** |
| 1. **Wish to be Dead:**

Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up.***Have you wished you were dead or wished you could go to sleep and not wake up?*** |  |  |
| 1. **Suicidal Thoughts:**

General non-specific thoughts of wanting to end one’s life/die by suicide, “*I’ve thought about killing myself”* without general thoughts of ways to kill oneself/associated methods, intent, or plan. ***Have you actually had any thoughts of killing yourself?***  |  |  |
| **If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6** |
| **3) Suicidal Thoughts with Method (without specific plan or intent to act):** Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. “*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*” ***Have you been thinking about how you might do this?***  |  |  |
| **4) Suicidal Intent (without specific plan):** Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as opposed to “*I have the thoughts but I definitely will not do anything about them*.” ***Have you had these thoughts and had some intention of acting on them?***  |  |  |
| **5) Suicide Intent with Specific Plan:** Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself and do you intend to carry out this plan?***  |  |  |
| **6) Suicide Behavior*****Have you done anything, started to do anything, or prepared to do anything to end your life?***Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn’t swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn’t jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. |  |  |

 Low Risk

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 Moderate Risk

 High Risk