PATIENT CHART

Zachary Alexander Miller - Simulation #2

SBAR Report Students Will Receive Before Simulation

**Time:** 1900

**Person providing report:** Day-shift nurse

**Situation:** Alex is a 15-year-old, who was admitted yesterday evening through the emergency department after being involved in a car-pedestrian accident.

**Background:** Alex was riding their bike home from a friend’s when hit by a car. Alex was admitted to the ER at 2200. They arrived on the unit this morning at 0800. Alex sustained a deep wound to the right torso. The car that hit them was an older model vehicle and had a rusty hood ornament. This caused the deep right torso wound. The physician has recommended that the wound be treated by packing it as per agency policy. Alex also fractured their right wrist and has some minor scratches and bruises to the right side of their body. Alex’s wrist was set (closed reduction) and a plaster cast applied in the ER. Alex was wearing a helmet and didn’t lose consciousness at the scene. Alex’s birth name is Zach, but they prefer to be called Alex. Their family is supportive of Alex’s gender identity and choice of name. Alex’s immunizations are up to date.

**Assessment:** Last vital signs taken at 1600 – HR - 75, RR - 18, BP – 120/70, 02 sats 98% on R/A, temp – 98.8 (37.1), pain 6/10. Last dose of acetaminophen given at 1600. Patient refused morphine. Torso wound - packing intact, some redness around edges of wound. Neurovascular assessment – no concerns. Plaster cast to right wrist intact. Alex is drinking fluids and says they don’t feel like eating anything solid. Alex says their whole-body hurts, but they don’t always take pain medication when it is offered. IV D5NS running at TKVO. Voiding as per home routine. Parent at bedside.

**Recommendation:** Complete a head-to-toe assessment. Focus on pain management as Alex seems reluctant to take analgesics when offered. Hang IV antibiotic (these should be prepared in a lab prior to starting the simulation)

Provider Orders

**Allergies/Sensitivities: NKA**

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Day 2/0800 | Admit to pediatric unitIV D5NS at 20ml/hrVital signs q 4hrs Neurovascular assessment q 4hrsChange dressing to right torso q shift starting tomorrowActivity as toleratedDiet as toleratedAcetaminophen 500mg PO q 4hrs prnIbuprofen 400mg PO q 6hrs prnMorphine 5mg IV q 3-4hrs prnCefazolin 1g IV q8hr |

Progress Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Day 1 2300 | 15-year-old Male admitted to ER. Brought in by ambulance after being involved in a pedestrian vehicle accident.Patient alert and oriented, but in significant pain, Vital signs stable, did not lose of consciousness at the scene.Respirations clear, abdominal sounds present x4, no abnormal heart sounds. Uncomplicated right distal radius fracture, x-rays and cast needed.Large 1.5-inch-deep, 4-inch long, full thickness, gaping wound to right torso– plan to clean and debride as soon as possible– ultrasound and x-ray of chest and abdomen show no damage to internal organs. Consult with plastics.Order labs and possible CT.Parents at bedside.Admit to pediatrics once stabilized. |
| Day 20200 | Closed reduction to right wrist. Plaster cast applied. Post reduction x-rays were obtained. |
| Day 20900 | 15-year-old male admitted to the pediatric unit from ER. Pedestrian/motor vehicle accident. Stable overnight. Continue with IV antibiotics for 2 days then switch to oral. After d/c, homecare to follow for wound care. Continue IV at TKVO. |

Nursing Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Day 20800 | Admitted patient from ER. Patient alert and oriented. Vital signs stable, pain 7/10. Patient refused morphine, so acetaminophen and ibuprofen were given. Cast to right wrist intact, movement, and sensation good. Right torso dressing dry and intact. Bruises and cuts to right side of body. Parent at bedside – no voiced concerns. IV intact with D5NS at 20ml/hr running. |
| 0830 | Pain 6/10. Patient refused morphine. |
| 1200 | Assessment remains unchanged from previous note. Denied need for additional pain medication. Stated he is sore, pain 5/10. Patient requested acetaminophen. Patient up to void since 0800 assessment. Taking sips of water and juice. States he doesn’t really feel hungry. |
| 1245 | Pain 6/10. Patient refused acetaminophen, but would like ibuprofen at 1400 |
| 1400 | Pain 6/10. Gave ibuprofen |
| 1435 | Pain to 5/10 |
| 1600 | Movement and sensation to right wrist remains unchanged. Pain to right torso 6/10. Patient requesting acetaminophen but refusing morphine. Writer explained the benefits of pain management in the healing process, but patient stated, “I’m okay, I don’t need anything else”. No other concerns. Parent at bedside. |

Medication Administration Record

Scheduled & Routine Drugs:

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Hours of Administration:** | **Date of administration:** | **Initials** |
| Day 2 | Cefazolin | 1g | IV | Every 8hr | 080012002000 | Day 2Day 2 | SSSS |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |

PRN and STAT Medications

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | **Initials** |
| Day2 | acetaminophen | 500mg | PO | Every 4hrs | Day 2 | 080012001600 | SSSSSS |
|  | ibuprofen | 400mg | PO | Every 6hrs | Day 2 | 08001400 | SSSS |
|  | morphine | 5mg | IV | Every 3-4hrs | Day 2 |  |  |
|  |  |  |  |  |  |  |  |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| SS | Sarah Smith |  |  |
|  |  |  |  |

Vital Signs Record

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date:** | **Day 2** | **Day 2** | **Day 2** |  |  |  |
| **Time:** | 0800 | 1200 | 1600 |  |  |  |
| **Temperature:** | 98 (36.7) | 99(37.0) | 98.8 (37.1) |  |  |  |
| **Heart Rate/Pulse:** | 76 | 72 | 75 |  |  |  |
| **Respirations:** | 16 | 18 | 18 |  |  |  |
| **Blood Pressure** | 118/70 | 110/65 | 120/70 |  |  |  |
| **O2  Saturation:** | 98% | 98% | 98% |  |  |  |
| **Weight:** |  |  |  |  |  |  |
| **Pain:** | 7/10 | 5/10 | 6/10 |  |  |  |
| **Nurse Initials:** | *ss* | *ss* | *ss* |  |  |  |

Medication Reconciliation Form

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

**Allergies/Sensitivities: NKA**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Medication Name** | **Dose** | **Route** | **Frequency** | **Reason** | **Last Dose** | **Continue/DC** |
| acetaminophen | 500mg | PO | Every 4hrs | Pain | X/XX/XX | [x]  C [ ]  DC |
| ibuprofen | 400mg | PO | Every 6hrs | Pain | X/XX/XX | [x]  C [ ]  DC |
| morphine | 5mg | IV | Every 3-4hrs | Pain | X/XX/XX | [x]  C [ ]  DC |
| cefazolin | 1g | IV  | Every 8hrs | Prophylactic for Infection | X/XX/XX | [x]  C [ ]  DC |

|  |
| --- |
| Signature RN: Sarah SmithPrint Name: Sarah Smith 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  | 8  | 4.1-10.9x10  |
| RBC  | 4.5 | 4.3-5.9x10  |
| HCT  | 40 | 40-50%  |
| HbG  | 14 | 13.2-17.5  |
| PLT  | 200 | 150-400x10  |

|  |  |  |
| --- | --- | --- |
| **Basic Metabolic Panel**  | **Result**  | **Reference Range**  |
| BUN  | 10  | 5-20 mg/dL  |
| Ca  | 9 | 8.5-10.2 mg/dL  |
| CL  | 100  | 98-107 mEq/L  |
| NA  | 135  | 134-144 mEq/L  |
| K  | 4.2 | 3.6-5.0 mEq/L  |
| Glucose  | 70 | 65-100 mg/dL  |
| CO2  | 25  | 23-29 mEq/L  |
| Creatinine  | 0.8  | 0.6-1.2 mg/dL  |

Intake & Output Bedside Worksheet

**INTAKE OUTPUT**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **ORAL** | **PO** | **IV** | **IVPB** | **OTHER** | **URINE** | **EMESIS** | **NG** | **Drains****Type:** | **Other** |
| Sips of water and juice |  | 240mL |  |  | Voiding reported by patient x2 on shift |  |  |  |  |
| **Total Intake this shift:**  | **Total Output this shift**: |