PATIENT CHART

Chart for Patrick Lake - Simulation #3

SBAR Report Students Will Receive Before Simulation

**Time:** 0900

**Person providing report:** Manager at home health agency

**Situation:** This will be Mr. Patrick Lake’s second home health visit since he was discharged from the hospital 3 days ago.

**Background:** Mr. Lake was admitted to hospital cardiac care unit 9 days ago with shortness of breath and heart rate of 130. He was diagnosed with new onset of heart failure. He responded to treatment and was discharged from the hospital 3 days ago and referred to the home health agency for follow-up. The client also has a past history of glaucoma, hypertension, osteoarthritis, hypercholesterolemia, atrial fibrillation, and an above-the-knee amputation from a war injury. Client is supposed to follow a low-fat, low-sodium diet.

**Assessment:** The nurse who conducted the first home health visit to Mr. Lake yesterday reported that he was alert and oriented x 3. His vital signs were: BP 128/84; heart rate 68 and regular; respirations 18 and temp of 98.9. His lungs were clear, but there were diminished breath sounds in the bases. He had trace edema in his foot and some general swelling of stump. All other peripheral pulses are palpable and +3. His weight was xxx lbs. Client complained his prosthetic leg was a little snug and he thought the stump was a little sore; however, there was no skin breakdown.

**Recommendation:** Complete a focused history and physical psychosocial exam and home health assessment according to the agency’s plan of care. Conduct any client or family teaching as needed. At the conclusion of your visit, if there are any significant findings, such as weight gain or shortness of breath, his primary care physician wants to be called.

**HOME HEALTH AGENCY PLAN OF CARE**

123 Main Street, Small Town, USA 12345

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| --- | --- | --- | --- | --- |
| **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:** Patrick Lake | **Provider:** Avery Smith, MD |
| **DOB:** 11-13-YYYY (reflect age 64)**Age:** 64 | **Provider Address:** 1010 Western Ave. Small Town, USA |
| **Address:** 111 Country Road, Suburbia | **Provider Phone:** 888-444-3333 |
| **Phone**: 555-666-1210 |  |

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| --- |
|  |
| **Principal Diagnosis:** Heart Failure(HF) |
| **Surgical Procedure:** NA |
| **Other Pertinent Diagnoses:** Glaucoma, hypertension, intermittent atrial fibrillation, osteoarthritis, hypercholesterolemia atrial fibrillation, above-the-knee amputation from war injury.  |
| **Durable Medical Equipment & Supplies:** walker **Safety Measures:** Standard fall precautions  |
| **Nutritional Requirements:** low-sodium, low-fat diet **Allergies:** No known allergies |
| **Functional Limitations** **X** Amputation ☐ Paralysis ☐ Legally blind ☐ Bowel/bladder **X**  Endurance ☐ Dyspnea on exertion ☐ Incontinence ☐ Ambulation ☐ Contracture ☐ Speech ☐ Hearing ☐ Other  |
| **Activities Permitted:** ☐ Complete bedrest ☐ BR/BRP ☐ Bed to chair **X** Up as tolerated **Assistive Devices****X** Walker ☐ Cane ☐ Crutches ☐ Wheel chair  |
| **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)**Skilled Nursing:3 times per week times for 9 weeks. Assess all systems. Instruct about nutrition, hydration, medications, home safety, emergency management, signs & symptoms to notify MD, energy conservation techniques.  |
| **Goals / Rehab Potential / Discharge Plan:**Stabilization of disease process. Rehab potential – good. Discharge to MD after goals are met. |
| **Nurse’s Signature:** Monica Adams, RN |

Provider Orders

**Allergies/Sensitivities:** None

|  |  |
| --- | --- |
| **Date/Time:** |  |
| On discharge from hospital | RN home visit daily x 2 weeks (call for further visits)   |
|  | **Diet:** Low fat; low sodium |
|  | **Weight** daily |
|  | **Vital Signs:** Q 4 hours |
|  | **Medications:**  |
|  |  Lisinopril 20 mg PO daily  |
|  |  Metoprolol 100 mg PO BID |
|  |  Potassium chloride 20mEq PO daily |
|  |  Apixaban 5 mg PO twice daily  |
|  |  Furosemide 40 mg PO daily  |
|  |  Atorvastatin 40 mg PO daily  |
|  |  Timolol 0.25% one drop twice a day to both eyes |
|  |  Acetaminophen 650 mg PO q 8 hrs prn for pain |
|  | Assess medication compliance |
|  | Assess home environment for safety |
|  | Notify health care provider if patient gains more than 3 pounds in one day, 5 or more pounds in one week, or reports shortness of breath. |
|  | Avery Smith, MD  |

Nursing Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Admission Note | Mr. Lake is alert and oriented x3 and responds appropriately to questions. He reports feeling pretty well today although he says he has been feeling pretty “down” since his hospitalization. This was the first home visit since his discharge and his weight is up 2 lbs. from his discharge weight. I reinforced the importance of watching his salt and fluid intake and taking his weight at the same time every day. Vital signs were stable today at BP 128/84, HR 68, R 18, and Temp 98.9. He denies any SOB at rest, dizziness, increased fatigue, chest pain or pressure, palpitations, orthopnea, or confusion. He reports mild dyspnea on exertion, but is able to complete his ADLs with the help of his wife. His lungs were clear but there were diminished breath sounds in the bases. He had trace edema in his foot and general swelling of his stump with no skin breakdown. His peripheral pulses were a +3. Heart rate and rhythm are regular. Mr. Lake states that he has been taking his medications as prescribed. I went over his medications with him again and stressed the importance of continuing to take his medications daily as prescribed. I also stressed the importance of adhering to a low-sodium, low-fat diet. Mr. Lake’s house appears safe with no concerns at this time and his wife appears to be very supportive and helpful.M. Adams, RN |

Vital Signs Record

|  |  |  |
| --- | --- | --- |
| **Date:** | **1st home visit**  | **2nd home visit**  |
| **Time:** | 1000 |  |
| **Temperature** | 98.9 |  |
| **BP:** | 128/84 |  |
| **Pulse:** | 68 |  |
| **O2 Saturation:** | 98% |  |
| **Respirations:** | 18 |  |
| **Nurse Initials:** | MA |  |

Weight Record

|  |  |  |  |
| --- | --- | --- | --- |
| **Date** | **Time** | **Daily weight** | **Reported by** |
| Day of discharge from hospital  | 8:00 AM | xxx | D. Gray, RN |
| First home visit | 10:00 AM | (up 2 lbs.) | M. Adams, RN |

24 Hour Diet Recall

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| --- | --- | --- |
| **Date** | **24 hr diet recall** | **Nurse Signature** |
| Home visit #1  | Breakfast - Eggs, bacon, toast, coffeeLunch- Turkey sandwich, chips, apple, diet cola Dinner: Pork chops, white rice, corn Snack: cheese and crackers | M. Adams, RN |

Home Safety Assessment

|  |  |  |
| --- | --- | --- |
|  | **Yes** | **No** |
| Floor free of clutter? | **X** |  |
| Throw rugs or other trip hazards present? |  | **X** |
| Medications properly labeled? | **X** |  |
| Fire hazards? (candles, electrical concerns, space heaters, smoking in or near sleeping area, clutter in kitchen near stove?) |  | **X** |
| Assistive device present and used? | **X** |  |
| Adequate lighting for safe movement? | **X** |  |
| Home free of visible pests? (insects, mouse droppings, etc.) | **X** |  |
| Possible food hazards (food needing refrigeration left out) |  | **X** |
| Other concerns: |  | **X** |