ACES

PATIENT CHART

Chart for Henry Williams simulation #3

STUDENT NAME:	
CLINICAL DATE(S):	
INSTRUCTOR:	

Patient Information Card

Patient Name: Henry Williams		**Gender:** Male	**DOB:** 03/01/xx (69/y)
Date Admit:	**Height:** 183 cm (72 in)	**Weight:** 88 kg (194 lbs)	**MRN:** 67549
Admit Diagnosis: COPD rehabilitation			**Location:** Rehab center Rm 5
Admit Provider: Dr. Katherine Nelson		**Allergies:** Penicillin	
Religion: Baptist		**Race:** African American	
Major support: Ertha (wife) and Betty (daughter-in-law)		**Immunizations:** Up to date	

Past Medical history:

Chronic obstructive pulmonary disease (COPD), cardiovascular disease (CVD), asthma, hearing loss (wears hearing aids).

History of present illness:

COPD. Henry has spent 15 days in the rehabilitation facility having therapy and education for managing his COPD and increasing his activity tolerance. He has improved greatly and uses his oxygen at night and only as needed. He has shown us that he knows how to do his breathing treatments and manage his medications. Now he and his wife Ertha are going to an assisted living apartment for the first time.

Social history:

Retired.

Primary medicial diagnosis:

COPD, cardiovascular disease.

Surgeries/procedures:

Appendectomy at age 15.

Physician's Orders

Patient Name: Henry Williams		**Gender:** Male	**DOB:** 03/01/xx (69/y)
Date Admit:	**Height:** 183 cm (72 in)	**Weight:** 88 kg (194 lbs)	**MRN:** 67549
Admit Diagnosis: COPD rehabilitation			**Location:** Rehab center Rm 5
Admit Provider: Dr. Katherine Nelson		**Allergies:** Penicillin	

Date/Time:	Physician's Orders
Day 5	**Discharge Medications:** Fluticasone propionate 250 mcg every 12 hours nebulized Albuterol inhaler 2 puffs as needed for acute onset of shortness of breath Rosuvastatin calcium 20 mg PO every evening Lisinopril 12.5 mg PO daily Metoprolol tartrate 50 mg PO daily Acetylsalicylic acid 81 mg PO daily Montelukast 10 mg PO every evening Prednisone 40 mg PO for 2 more days, then 20 mg for 5 days, then 10 mg for 5 days and follow up in the clinic for further orders Albuterol nebulizer treatment 2.5 mg & pratropium bromide 0.5 mg in 3 mL normal saline every 4 hours and as needed (decrease frequency, as tolerated)
Day 15	**Discharge orders:** Fluticasone proprionate 250 mcg every 12 hours nebulized Albuterol 2 puffs as needed for acute onset of shortness of breath Albuterol nebulizer treatment 2.5 mg & Ipratropium bromide 0.5 mg in 3 mL normal saline every night and as needed for breathing changes/shortness of breath. Rosuvastatin calcium 20 mg PO every evening Lisinopril 12.5 mg PO daily Metoprolol tartrate 50 mg PO daily Acetylsalicylic acid 81 mg PO daily Montelukast 10 mg PO every evening Prednisone 10 mg PO daily Schedule clinic appointment for evaluation in 10 days.

Provider signature: Dr. Ipsum Larum

Nursing Notes

Patient Name: Henry Williams		**Gender:** Male	**DOB:** 03/01/xx (69/y)
Date Admit:	**Height:** 183 cm (72 in)	**Weight:** 88 kg (194 lbs)	**MRN:** 67549
Admit Diagnosis: COPD rehabilitation			**Location:** Rehab center Rm 5
Admit Provider: Dr. Katherine Nelson		**Allergies:** Penicillin	

Date/Time:	Nursing Notes

Nurse signatures

Initial	Nurse Signature	Initial	Nurse Signature

Vital Signs Record

Patient Name: Henry Williams		**Gender:** Male	**DOB:** 03/01/xx (69/y)
Date Admit:	**Height:** 183 cm (72 in)	**Weight:** 88 kg (194 lbs)	**MRN:** 67549
Admit Diagnosis: COPD rehabilitation			**Location:** Rehab center Rm 5
Admit Provider: Dr. Katherine Nelson		**Allergies:** Penicillin	

Date											
Time											
Temperature	C° 40	F° 104									
	39.5	103									
	39	102									
	38.5	101									
	38	100									
	37.5	99									
	37	98									
	36.5	97									
	36	96									
BP											
Pulse											
O_2 saturation											
Weight											
Respirations											
GMR											
Nurse Initials											

Nursing Assessment Flowsheet

Patient Name: Henry Williams		**Gender:** Male	**DOB:** 03/01/xx (69/y)
Date Admit:	**Height:** 183 cm (72 in)	**Weight:** 88 kg (194 lbs)	**MRN:** 67549
Admit Diagnosis: COPD rehabilitation			**Location:** Rehab center Rm 5
Admit Provider: Dr. Katherine Nelson		**Allergies:** Penicillin	

GENERAL APPEARANCE:
[ ] awake [ ] cheerful [ ] crying [ ] sleeping [ ] lethargic
[ ] calm [ ] agitated [ ] anxious [ ] combative [ ] fearful

SKIN: [ ] (see wound care sheet) [ ] see nursing notes
Braden scale score: [ ] risk skin breakdown
COLOR: [ ] acyanotic [ ] pale [ ] ruddy [ ] jaundiced
[ ] cyanotic
TEMP: [ ] warm/dry [ ] hot [ ] cool [ ]c old/clammy
[ ] diaphoretic
TURGOR: [ ] < 3 sec [ ] > 3 sec
HAIR: [ ] shiny [ ] dry/faking [ ] balding [ ] lesions [ ] lice

RESPIRATORY: [ ] see nursing notes
RESPIRATIONS: Rate_____ O2_____ SPO2_____%
[ ] reg [ ] even [ ] irreg [ ] labored
[ ] uses accessory muscles [ ] cough
BREATH SOUNDS:
RIGHT: [ ] clear [ ] crackles [ ] wheezes [ ] decreased
[ ] absent
Left: [ ] clear [ ] crackles [ ] wheezes [ ] decreased [ ] absent
THORAX: [ ] even expansion [ ] uneven expansion
SMOKING: cigarettes pk/day_____ [ ] cigars
[ ] marijuana [ ] cocaine

NEUROLOGICAL: [ ] see nursing notes
ORIENTATION: [ ] person [ ] place [ ] time
[ ] Disoriented: [ ] confused [ ] impaired memory
RESPONDS TO: [ ] name [ ] stimuli [ ] non-responsive
SPEECH: [ ] clear [ ] garbled [ ] slurred [ ] aphasic
[ ] inappropriate [ ] cannot follow conversation
FACE: [ ] symmetrical [ ] drooping [ ] drooling
EYES: [ ] PERRLA [ ] unequal [ ] drooping lid
SIGHT: [ ] no correction [ ] glasses [ ] contacts [ ] blind
HEARING: [ ] WNL [ ] HOH [ ] hearing aid
Hx: [ ] seizures [ ] CVA [ ] brain injury [ ] spinal injury [ ] other

GASTROINTESTINAL/NUTRITION [ ] see nursing notes
APPEARANCE: [ ] flat [ ] round [ ] obese [ ] soft [ ] gravid
BOWEL SOUNDS:
[ ] active [ ] hypoactive [ ] hyperactive [ ] absent
PALPATION:
[ ] non-tender [ ] tender (location)_____
[ ] mass (location) _____
LAST BM:_____ [ ] incontinent [ ] stoma- _____
[ ] constipation [ ] diarrhea [ ] mucous [ ] blood
Diet:_____ [ ] impaired swallowing [ ] choking
[ ] NG tube Color drainage_____ [ ] Feeding tube
[ ] tube feeding Type: _____ Rate:_____

MUSCULOSKELETAL: [ ] see nursing notes
GAIT: [ ] steady [ ] unsteady [ ] non-ambulatory
ACTIVITY: [ ] up ad lib [ ] walker [ ] cane [ ] crutches
[ ] wheelchair
Assist: [ ] x1 [ ] x2 [ ] lift [ ] bed bound
HAND GRIPS: Amputation [ ] right [ ] left
Location_____
RIGHT: [ ] strong [ ] weak [ ] flaccid [ ] contractures
LEFT: [ ] strong [ ] weak [ ] flaccid [ ] contractures
ROM:
ARMS: [ ] full [ ] weak [ ] flaccid [ ] contractures
LEGS: [ ] full [ ] weak [ ] flaccid [ ] contractures [ ] TED hose
AMPUTATION: [ ] right [ ] left [ ] BKA [ ] AKA [ ] other
SPINE: [ ] kyphosis [ ] scoliosis [ ] osteoporosis
OTHER: [ ] Cast location:_____
[ ] Traction_____

GENITOURINARY: [ ] see nursing notes [ ] Voids [ ] catheter
[ ] stoma
APPEARANCE OF URINE:
[ ] clear [ ] light yellow [ ] amber [ ] brown [ ] cloudy
[ ] sediment [ ] red/wine [ ] clots
BLADDER: [ ] soft [ ] firm/distended [ ] incontinent

FEMALES: LMP:_____ [ ] WNL [ ] dysmenorrheal
Birth control: [ ] yes [ ] no [ ] BSE monthly
[ ] menopause [ ] taking estrogen

SEXUALITY: [ ] sexually active [ ] safe sex
MED Hx: [ ] urinary retention [ ] BPH [ ] Frequent UTI

Nursing Assessment Flowsheet – Continued

Patient Name: Henry Williams		**Gender:** Male	**DOB:** 03/01/xx (69/y)
Date Admit:	**Height:** 183 cm (72 in)	**Weight:** 88 kg (194 lbs)	**MRN:** 67549
Admit Diagnosis: COPD rehabilitation			**Location:** Rehab center Rm 5
Admit Provider: Dr. Katherine Nelson		**Allergies:** Penicillin	

CARDIOVASCULAR: [ ] see nursing notes
HEART SOUNDS: [ ] normal S1-S2 [ ] Abnormal S3-S4 [ ] murmur
PULSE: APICAL: [ ] reg [ ] irreg [ ] strong [ ] faint
RADIAL: [ ] reg [ ] irreg [ ] strong [ ] faint [ ] nonpalpable
PEDALIS: [ ] reg [ ] irreg [ ] strong [ ] faint [ ] nonpalpable
EXTREMITY COLOR & TEMP:
[ ] warm [ ] cool [ ] cold [ ] acyanotic [ ] cyanotic [ ] discolor
EDEMA: [ ] none [ ] generalized (anasarca)
Site #1_____
[ ] pitting [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+ [ ] non-pitting
Site #2 _____
[ ] pitting [ ] 1+ [ ] 2+ [ ] 3+ [ ] 4+ [ ] non-pitting
CAPILLARY REFILL: Fingers [ ] brisk [ ] slow
Toes: [ ] brisk [ ] slow
Hx: [ ] Pacemaker [ ] HTN [ ] CAD [ ] CHF [ ] PVD
Other:_____

PAIN ASSESSMENT: [ ] see nursing notes [ ] see MAR
PRECIPITATING:_____
QUALITY:_____
REGION:_____
SEVERITY 0-10/10: Now _____ at worst _____ at best _____
TIMING:

SAFETY: [ ] see nursing notes [ ] Fall risk
PRECAUTIONS: [ ] side rails x_____ [ ] bed down [ ] call light
[ ] nightlight [ ] restraints [ ] wrist [ ] vest

DISCHARGE/TEACHING: [ ] see nursing notes
NEEDS:_____
_____
TYPE OF LEARNER: [ ] visual [ ] auditory [ ] kinesthetic
Educational level _____ Family present: [Y] [N]

FLUID BALANCE [ ] see nursing notes
INTAKE: [ ] PO [ ] IV: Solution: _____Rate_____ ml/hr
SITE LOCATION: _____ [ ] clean [ ] patent
[ ] redness [ ] swelling [ ] cool [ ] hot [ ] pain
[ ] tubing change [ ] dressing change
MUCOUS MEMBRANES: [ ] moist [ ] pink [ ] dry [ ] sticky [ ] coated
Today's wt:_____ Yesterday's wt:_____

NURSE SIGNATURE:
Time completed:
REASSESSMENT:
TIME _____ [ ] no change [ ] see nurses notes [ ] initials___
TIME _____ [ ] no change [ ] see nurses notes [ ] initials___
TIME _____ [ ] no change [ ] see nurses notes [ ] initials___

Risk Assessments & Nursing Care

Patient Name: Henry Williams		**Gender:** Male	**DOB:** 03/01/xx (69/y)
Date Admit:	**Height:** 183 cm (72 in)	**Weight:** 88 kg (194 lbs)	**MRN:** 67549
Admit Diagnosis: COPD rehabilitation			**Location:** Rehab center Rm 5
Admit Provider: Dr. Katherine Nelson		**Allergies:** Penicillin	

	Date: **Braden Scale Score:** **Fall Risk Score:**								**Date:** **Braden Scale Score:** **Fall Risk Score:**							
Time																
PAIN ASSESSMENT																
Intensity (1-10/10)																
Pain Type (see legend)																
Intervention (see legend)																
PATIENT POSITION																
PO FLUIDS (ml)																
IV SITE/RATE CHECKED																
PATIENT HYGIENE																
WOUND ASSESSMENT																
WOUND BED																
WOUND DRAINAGE																
WOUND CARE																
Nurse Initials:																

Nurse signatures

Initial	Nurse Signature	Initial	Nurse Signature

LEGEND: *= see nursing notes

PAIN TYPE:

A - aching
ST - stabbing
SH - shooting
T - throbbing
B - burning
P - pressure

PAIN INTERVENTIONS:

1 - Relaxation/Imagery
2 - Distraction
3 - Reposition
4 - Medication

POSTIONING:

B - back
R - right
L - left
C - chair
A - ambulatory

PT. HYGIENE:

b - bedbath
p - partial bath
g - grooming
f - foot care
a - assist bath
sh - shower
m - mouth care
n - nail care

WOUND ASSESSMENT:

 # 1-4 Pressure Ulcer stage
I – Incision
R – Rash
SK – skin tear
E – Echymosis
A – Abrasion

WOUND BED:

D – Dry & intact
S – Sutures/ staples
G – Granulation tissue
P – Pale
Y – Yellow
B – Black

WOUND DRAINAGE:

0 – none
S – Serous
P – Purlulent
S – Serosanguinous
B – Bright red blood
D – Dark old blood

WOUND CARE:

C – Cleaned with NS
G – Gauze dressing
W – Gauze wrap
A – ABD pad
M – Medication
O – other **

Medication Reconciliation Form

Patient Name: Henry Williams		**Gender:** Male	**DOB:** 03/01/xx (69/y)
Date Admit:	**Height:** 183 cm (72 in)	**Weight:** 88 kg (194 lbs)	**MRN:** 67549
Admit Diagnosis: COPD rehabilitation			**Location:** Rehab center Rm 5
Admit Provider: Dr. Katherine Nelson		**Allergies:** Penicillin	

Date:

Current Medication	Dose	Route	Frequency	Last Dose	Reconciled

New Medication	Dose	Route	Frequency	Last Dose	Reconciled

Medications reviewed by RN? Yes ☐ No ☐

Medications reviewed with patient? Yes ☐ No ☐

Comments:

Nurse Signature: **Date/Time:**

Written Discharge Instructions

Patient name:		**DOB:**	
Physician name:			
Discharge Diagnosis:			
Patient instruction:			
Teaching done and patient readiness to learn:			
Patient able to demonstrate "teach-back" method: Yes ☐ No ☐ If No, please discuss teaching method.			
Home Medication: Use the Medication Reconciliation form if being transferred to another facility.			
Follow up Appointments:			
Clinic:	**Doctor:**	**Date:**	**Time:**
Other:			
Documentation of receipt of discharge instructions:			
Patient Signature:		**Family Signature:**	
Witness:		**RN:**	

SBAR

Before calling the provider:

1. Assess the patient
2. Have charts and relevant information in front of you

SBAR report	Patient information	Notes
Situation	Identify yourself Patient's name and reason for report Concerns:	
Background	History includes: Current problems are: Any patient complaints and pain level	
Assessment	Vital signs Lab Values Interventions completed Give your conclusions	
Recommendation	What I need from you is: Be specific about a time frame Suggestions for tests/treatments: Verify orders and when to call back	