

PATIENT CHART

Chart for Sherman "Red" Yoder Simulation #2

STUDENT NAME: _____

PATIENT INITIALS: ___ S.Y. _____

CLINICAL DATE(S): _____

INSTRUCTOR: _____

Patient Name: Sherman “Red” Yoder Room: 16 DOB: 02/02/1931 Age: 80	MRN: 000-555-555 Doctor Name: Dr. Frank Baker Date Admitted:
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Physician’s Orders

Allergies: NKA

Date/ Time:	
	Emergency Room orders:
	IV 0.9% NS 500mL bolus; may repeat once
	Labs: CBC, electrolytes, BUN and creatinine, arterial blood gases, blood cultures x 2, serum lactate
	Wound culture and sensitivity
	Oxygen at 2 liters per minute via nasal cannula; titrate to keep SpO2 > 94%
	Insert urinary catheter to continuous drainage
	Continuous ECG and Sp O2 monitoring
	Ceftazidime 1 gram IVPB every 8 hours
	Capillary blood glucose stat: Administer regular insulin per sliding scale below: If less than 60 notify Dr. Baker 61-130- give no insulin 131-200- give 2 units subcutaneously 201-250- give 4 units subcutaneously 251-300- give 6 units subcutaneously >300 notify Dr. Baker
	Transfer to medical intensive care unit
	Dr. Frank Baker

Physician Progress Notes

Allergies: NKA

Date/Time:	
	Dr. Frank Baker

Nursing Notes

Date/Time:	
	Patient is an 80-year-old male admitted via ambulance. He has a history of diabetes and an open foot wound. See physician orders then transfer to MICU.
	John Smith, RN

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
JS	John Smith, RN		

Medication Administration Record

Allergies: NKA

Scheduled & Routine Drugs

Date of Order:	Medication:	Dosage:	Route:	Frequency:	Hours to be Given:	Date Given:
	Ceftazidime	1 gram	IVPB	every 8 hours		

Intravenous Therapy

Date of Order:	IV Solution	Rate Ordered:	Date/Time Hung:
	IV 0.9%	NS 500 cc's bolus, may repeat x1	

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature
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Medication Administration Record

Intramuscular legend:	Subcutaneous site code:
A=RUOQ ventrogluteal	1=RUQ abdomen
B=LUOQ ventrogluteal	2=LUQ abdomen
C=R Deltoid	3=RLQ abdomen
D=L Deltoid	4=LLQ abdomen
E=R Thigh Lateral	5=RU arm
F=L Thigh Lateral	6=LU arm
	7=R leg
	8=L leg

Allergies: NKA

PRN Medications

Date of Order:	Medication:	Dosage:	Route:	Frequency :	Date/Time Given:	
					Date:	
					Time:	
					Site:	
					Initials :	

Insulin Administration

Date of Order:	Medication:	Dosage:	Route:	Frequency :	Date/Time Given:	
					Date:	
					Time:	
					Site:	
					GMR:	
					Initials :	

Nurse Signatures

Initial	Nurse Signature	Initial	Nurse Signature

Vital Signs Record

			Date:									
			Time:									
			040	080	1200	160	200	240	040	080	120	160
			0	0		0	0	0	0	0	0	0
Temperature:	C°	F°	.	.	.	.	.	.	.	.	.	.
	40	104	.	.	.	.	.	.	.	.	.	.
	39.5	103	.	.	.	.	.	.	.	.	.	.
	39	102	.	.	.	.	.	.	.	.	.	.
38.5	101	.	.	.	.	.	.	.	.	.	.

		
		
	38	100	.	.	X	.	.	.	.	.	.	.
		
	37.5	99	.	.	.	.	.	.	.	.	.	.
		
	37	98	.	.	.	.	.	.	.	.	.	.
		
	36.5	97	.	.	.	.	.	.	.	.	.	.
		
	36	96	.	.	.	.	.	.	.	.	.	.
		BP			116/84							
		Pulse			86							
		O ² Saturation										
		Weight										
		Respirations			28							
		GMR										
		Nurse Initials			JS							

Intake & Output Bedside Worksheet

INTAKE					OUTPUT				
ORAL	TUBE FEED	IV	IVPB	OTHER	URINE	Emesis	NG	Drains Type:	Other

Total Intake this shift:					Total Output this shift:				

(This is a worksheet to be used at the bedside to keep track of each intake or output. The totals will then be recorded on the 24 hour Fluid Balance sheet.)

Fluid Measurements:	Sample Measurements:
1 ml = 1 cc	Coffee cup = 200 cc
1 ounce = 30 cc	Clear glass = 240 cc
8 ounces = 240 cc	Milk carton = 240 cc
1 cup = 8 ounces = 240 cc	Small milk carton = 120 cc
4 cups = 32 ounces = 1 quart or liter = 1000 cc	Juice, gelatin or ice cream cup = 120 cc
	Soup bowl = 160 cc
	Popsicle half = 40 cc

Nursing Assessment Flowsheet

GENERAL APPEARANCE:
 male female
DOB: 6/9/1938
AGE: 80
ETHNICITY: Caucasian
OCCUPATION: Retired farmer
RELIGION: Protestant

awake sleeping agitated
 cheerful lethargic anxious
 crying calm combative
 fearful

SKIN: see wound care sheet see nursing notes

BRADEN SCALE SCORE: 15 risk skin breakdown

COLOR:
 acyanotic
 pale
 ruddy
 jaundiced
 cyanotic

TURGOR:
 <3 sec
 > 3 sec

TEMP:
 warm/dry
 hot
 cool
 cold/clammy
 diaphoretic

HAIR:
 shiny
 dry/flaking
 balding
 lesions
 lice

R foot is red and swollen, there is an open wound to the R great toe, depth of 1cm and width 1cm, purulent drainage noted

NEUROLOGICAL: see nursing notes

ORIENTATION:
 person disoriented
 place confused
 time impaired memory

RESPONDS TO:
 name non-responsive
 stimuli

RESPIRATORY: see nursing notes

RESPIRATIONS:
RATE: 28
O₂: RA
SPO₂: 88%

regular labored
 even uses accessory muscles
 irregular cough

BREATH SOUNDS:

LEFT:
 clear
 crackles
 wheezes
 decreased
 absent

RIGHT:
 clear
 crackles
 wheezes
 decreased
 absent

THORAX:
 even expansion
 uneven expansion

SMOKING:
 cigarettes pk/day _____
 cigars
 marijuana
 cocaine

GASTROINTESTINAL/NUTRITION: see nursing notes

APPEARANCE:
 flat soft
 round gravid
 obese

BOWEL SOUNDS:
 active hyperactive
 hypoactive absent

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

PALPATION:
 non-tender
 tender (location) _____
 mass (location) _____

LAST BM: __yesterday_____
 incontinent
 stoma- _____
 constipation
 diarrhea
 mucous
 blood

DIET: __Low fat_____
 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: left right
 LOCATION: _____

LEFT:
 strong
 weak
 flaccid
 contractures

RIGHT:
 strong
 weak
 flaccid
 contractures

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

ROM:

ARMS:
 full
 weak
 flaccid
 contractures

LEGS:
 full
 weak
 flaccid
 contractures
 TED hose

AMPUTATION:
 right
 left

SPINE:
 kyphosis
 scoliosis

OTHER:
 CAST LOCATION: _____
 TRACTION: _____

taking estrogen

SEXUALITY:
 sexually active safe sex

MED HX:
 urinary retention
 BPH
 Frequent UTI

CARDIOVASCULAR: see nursing notes

HEART SOUNDS:
 normal S₁-S₂ abnormal S₃-S₄ murmur

PULSE:

APICAL:	RADIAL:	PEDALIS:
<input type="checkbox"/> regular	<input type="checkbox"/> regular	<input type="checkbox"/> regular
<input type="checkbox"/> irregular	<input type="checkbox"/> irregular	<input type="checkbox"/> irregular
<input type="checkbox"/> strong	<input type="checkbox"/> strong	<input type="checkbox"/> strong
<input type="checkbox"/> faint	<input type="checkbox"/> faint	<input type="checkbox"/> faint
	<input type="checkbox"/> nonpalpable	<input type="checkbox"/> nonpalpable

PAIN ASSESSMENT: see nursing notes
 see MAR

PRECIPITATING: _____

QUALITY: __throbbing_____

REGION: __R foot_____

SEVERITY (0-10/10):
 NOW: __5__ AT WORST: __8__ AT BEST: __4__

TIMING: __constant_____

EXTREMITY COLOR & TEMP:
 warm acyanotic
 cool cyanotic
 cold discolor

EDEMA:
 none generalized (anasarca)

SITE #1: _____ SITE #2: _____

pitting pitting
 1+ 1+

SAFETY: see nursing notes
 fall risk

PRECAUTIONS:
 side rails x __2__ restraints
 bed down wrist
 call light vest
 nightlight

DISCHARGE/TEACHING: see nursing notes

<input type="checkbox"/> 2+	<input type="checkbox"/> 2+
<input type="checkbox"/> 3+	<input type="checkbox"/> 3+
<input type="checkbox"/> 4+	<input type="checkbox"/> 4+
<input type="checkbox"/> non-pitting	<input type="checkbox"/> non-pitting

CAPILLARY REFILL:

FINGERS:	TOES:
<input type="checkbox"/> brisk	<input type="checkbox"/> brisk
<input type="checkbox"/> slow	<input type="checkbox"/> slow

HX:

<input type="checkbox"/> Pacemaker	<input type="checkbox"/> CHF
<input type="checkbox"/> HTN	<input type="checkbox"/> PVD
<input type="checkbox"/> CAD	<input type="checkbox"/> Other: _____

NEEDS
: _____

TYPE OF LEARNER:

visual
 auditory
 kinesthetic

EDUCATIONAL LEVEL: ___normal___

FAMILY PRESENT:

yes
 no

FLUID BALANCE: see nursing notes

INTAKE:

PO IV

SOLUTION: _ RATE: _

SITE LOCATION: _ R FA 20g _____

<input type="checkbox"/> clean	<input type="checkbox"/> swelling	<input type="checkbox"/> pain
<input type="checkbox"/> patent	<input type="checkbox"/> cool	<input type="checkbox"/> tubing change
<input type="checkbox"/> redness	<input type="checkbox"/> hot	<input type="checkbox"/> dressing change

MUCOUS MEMBRANES:

<input type="checkbox"/> moist	<input type="checkbox"/> sticky	<input type="checkbox"/> dry
<input type="checkbox"/> pink	<input type="checkbox"/> coated	

TODAY'S WT:109kg **YESTERDAY'S WT:**110kg

NURSE SIGNATURE: _____

TIME COMPLETED: _____

REASSESSMENT:

TIME: _____

<input type="checkbox"/> no change	<input type="checkbox"/> see nurses notes	<input type="checkbox"/> initials _____
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TIME: _____

<input type="checkbox"/> no change	<input type="checkbox"/> see nurses notes	<input type="checkbox"/> initials _____
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TIME: _____

<input type="checkbox"/> no change	<input type="checkbox"/> see nurses notes	<input type="checkbox"/> initials _____
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UA	Urine color: dark amber, cloudy Specific gravity: 1.050 (normal 1.005- 1.035) ph 6.0 (normal 4.5-8.0) RBC - 9 (normal 0-2) WBC - 150,000 (normal 0-5)	
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LAB TEST	RESULT	NORMAL RANGE
WBC	12,000	
HGB	9.9	
HCT	32	
NA+	149	
K+	3.5	
GLUCOSE	105	