

ROOM NO: 335
 NAME: PEDROSA, JOSEPH
 DOB: 8/21/XXXX AGE: 65/M
 MR#: 012345
 DR. SMITH, S

Situation

Chief Complaint / Diagnosis:

Pneumonia/Empyema

Allergy: Fluoroquinolones **Code status:** Full

Background

Pertinent Medical History: GERD, Diabetes type 2, Hypertension, Smoker

Home Medications: Glucophage, Protonix, Lisinopril

Pertinent RECENT History: Developed shortness of breath and fever 6 days ago. Right lower lobe pneumonia with loculated empyema. Unable to obtain IV access. Right Triple Lumen Central Line placed 2 days ago.

Assessment

Current Vital Signs : T 99.0, HR 92, R 24, B/P 138/92, O2Sat 95 on 2LNC. Right pleuritic pain is reported by the patient as 2 on the 0-10 pain scale.

Safety Concerns: Risk for falls.

Pertinent Assessment: Right Triple Lumen Central Line. Patient perspiring a lot. Having difficulty keeping central line dressing in place. Voids. Last medicated for Right pleuritic pain 2 hours ago. 0630 Accucheck result was 220. Insulin Coverage not yet given.

Pertinent Lab / Dx test results: CBC, BMP results at 2030 on day of admission

Lab	Patient	Ref. Range
CBC		
WBC	22,000	4,000-10,000
RBC	4.20	4.20-5.70
Hgb	14	12-18
Hct	42	38-45

Lab	Patient	Ref. Range
BMP		
Na	138	135-145
K	4.9	3.5-5.0
BUN	26	10-20
Creat	1.8	0.2-1.2
Glucose	185	70-110
Ca	9	8.0-10.0
CO2	24	23-28

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Physician Orders:

Admit to med/surg unit

Diagnosis: Pneumonia/Empyema

Full Code

Fall precautions

1800 ADA diet

Accudata checks AC and HS

Sliding Scale Insulin Protocol - Regular Insulin

Hypoglycemia Protocol

 Blood glucose 50-79 in an ALERT patient

 If able to tolerate PO, give 4 oz of Orange or Apple Juice

 If NPO or unable to swallow, give 1 amp of D50 IV

 Recheck blood glucose in 15 minutes

Normal Saline 50 ml/hr continuous infusion

Change central line dressing Q7 days and PRN

Hydrocodone/Acetaminophen 7.5 mg/500 mg 1 tablet PRN Pain

Oxygen to keep saturation above 92%

Recommendation

Enter room; prioritize care according to subjective and objective data

- Implement and maintain universal competencies
- Prioritize and implement nursing interventions
- Perform focused assessment

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Medication Administration Record

Allergies: Fluoroquinolones

Start Stop	Medication	Dose	Next Sched	History	Assoc
		Route	Ack/View Ord	Monograph	Assmnt
Current Status		Frequency	Adjustment	Co-Sign	Ref Err
X/XX/201X	Regular Insulin 100 units/mL 3 mL Vial	(See Protocol)	AC	Yesterday 2100 2 Units	
X/XX/201X		SUBCUT	ACK		
Active		AS DIRECTED PRN SEE PROTOCOL			Co-Sign

Label Comments

Based on Blood Glucose Monitoring

Protocol

	Condition	Dose/Route	Instruction
1	Blood Sugar	Insulin Coverage	
2	-----	-----	-----
3	Less than 50	See Hypoglycemia Protocol	Notify MD
4	50-79	See Hypoglycemia Protocol	
5	80-149	0 units	
6	150-200	2 units	
7	201-250	4 units	
8	251-300	6 units	
9	301-350	8 units	
10	351-450	10 units	Notify MD

[More ...](#)

X/XX/201X	0.9 % Normal Saline 1000 mL	50 mL/hr	0300	Today 0700	
X/XX/201X		IV	ACK		
Active		Continuous			
X/XX/201X	Hydrocodone/Acetaminophen 7.5 mg/500 mg 1 tablet	7.5/500 mg <1 Tablet>		Today 0645	
X/XX/201X		PO	ACK		
Active		Every 4 Hours PRN Pain >5			

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Room and Mannequin Setup

Initial Monitor Settings: T 99.0, HR 92, R 24, B/P 138/92, O2Sat 92 on RA.

Bed: HOB at 30°

SimMan Assessment settings:

Neuro: Alert and oriented to person, place, and time.

Lungs: Clear

CV/IPV: Regular rhythm and rate, radial pulses strong bilat, weak pedal pulses

Abdomen: Normal bowel sounds

Skin: Intact, RTLSC

GU: Voids

Room Supplies	Number	Mannequin Setup
		RTL Subclavian IV access
Alcohol swabs	1 box	Armband
Insulin syringes	10	Allergy band
Regular Insulin	2	Injection pad on left abdomen
Normal Saline 0.9% 1000 mL	1	
Primary IV Tubing	1	Male manikin
Nasal Canula	1	
Blue medication labels	10	
Central Line Kit	2	