

VINCENTE, GABRIELLE
DOB: 07/15/XXXX AGE: 54/F
MR#: 022346
Jesse, John, MD

Situation: Chief Complaint/Diagnosis: Right foot ulcer with purulent drainage

ALLERGY: NKDA Code Status: Full Code

Background: History: GERD, Type 2 Diabetes, Smoker, Hypertension

Home Meds: Lisinopril, Protonix, Glucophage

Pertinent recent history: 54 year old female. Receiving home health care for right great toe diabetic ulcer. Now with purulent drainage and fever. Patient was admitted 2 days ago for antibiotic therapy and wound care.

Assessment: Last Vital Signs: T: 101.1 P: 92 R: 24 B/P: 138/92, O2 Sat: 92% on Room Air

Safety concerns: Risk for falls due to right foot dressing

Last Assessment: Right subclavian central line. IV of NS at 50 ml/hr. Patient voiding with no complaint. Right great toe 6 cm X 4 cm open ulcer with purulent drainage.

Awake, alert, & oriented to time and place. Lungs: clear to auscultation. Heart: regular rate and rhythm, no murmur. Abd: soft, non-tender, normoactive bowel sounds. Peripheral pulses are present equal and bilateral. C/O pain to right toe/foot. No edema noted to extremities. The central line dressing is clean and dry, but is coming loose at one corner.

Wound care with dressing change done this morning. Photo of wound on chart.

Patient is requesting to leave the floor to smoke.

Patient's AM insulin has been given and patient has had breakfast.

Has been having significant pain to right toe/foot.

Last pain medication was given 2 hours ago.

Pain last reported as a 2-3 on 0-10 scale after pain med given.

Patient is due for antibiotic.

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PHYSICIAN ORDERS

Admit to med/surg floor

Dx: Infected right foot ulcer

Full Code

Fall Precautions

1800 ADA Diet

Wound care dressing change BID with Chloraprep and cover with gauze dressing.

Accucheck AC & HS

Sliding Scale Insulin Protocol

Cefuroxime 750 mg IVPB every 8 hours

Morphine 4 mg IV every 6 hours as needed for pain moderate pain.

Right subclavian central line

IV Fluids: Normal Saline @ 50 ml/hr

Recommendation:

Prioritize and implement nursing interventions

Perform focused assessment

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MEDICATION ADMINISTRATION RECORD

| Start Stop Current Status | Medication | Dose | Next Sched | History | Assoc |
|---------------------------------|--|-----------------------------|----------------------------|----------------------|------------------|
| | | Route Frequency | Ack/View Ord Adjustment | Monograph Co-sign | Asmnt Ref Err |
| 01/18/17 1100 | Rx CM00011450 HumuLIN R Insulin Regular 100 units/mL 3 mL Vial | (See Admin Instructions) | DONE 0600 | | ▶ |
| Active | | SUBCUT ACHS | ACK - NEW | ▶ | ▶ |

Label Comments
 INSULIN Category: Short Acting
 Give 30 minutes prior to meal

Dose Instructions
 See Protocol

Protocol

| Condition | Dose/Route | Instruction |
|-------------------------------|-----------------------|------------------------------|
| If CBG less than 70, initiate | Hypoglycemia Protocol | |
| 70-140 | give 0 unit | |
| 141-190 | give 3 units | |
| 191-240 | give 6 units | |
| 241-290 | give 9 units | |
| 291 or greater | notify physician | consider IV insulin infusion |

| | | | | | |
|---------------|---|-------------|-----------|---|---|
| 10/13/16 0900 | Rx CM00000000 CEFUROXIME 750 mg/50ml IVPB 50ml CEFUROXIME 750 mg/50ml IVPB 50ml | 100 MLS/HR | 0900 | | ▶ |
| Active | | IVPB Q8H | ACK - NEW | ▶ | |

Label Comments
 * Black box warning *

| | | | | | |
|---------------|--|---|-----------|---|---|
| 01/18/17 0900 | Rx CM00011446 morphine Inj morphine Inj 4 mg/1 mL Vial | 4 MG < 1 ML > | | | ▶ |
| Active | | IVP Q6H PRN PAIN, Severe (7-10) | ACK - NEW | ▶ | ▶ |
| | | | 0615 crs | | |

