

Mandy Rhodes | Fever, possible bacterial meningitis

MR: 1875519

DOB: 9/9/xxxx Age: 4 years old

Sarah Meyers MD

Allergy: azithromycin



Location: Pediatric Unit

Patient name: Mandy Rhodes

Medical record #: 1875519

Date of birth: September 9

Age: 4 years

Sex: Female

Admitting provider: Sarah Meyers, MD

Scenario start day: Day 1, Friday

Scenario start time: 1600

Chief complaint upon admission: Fever

Primary diagnosis: Fever, possible bacterial meningitis

Secondary diagnosis: Headache



SBAR Hand-Off	Current day and time:	Friday 1600	Admission day and time:	Friday 1500	
Situation	Name:	Mandy Rhodes			
	Age:	4 years	Sex:	Female	
	Provider:	Sarah Meyers, MD			
	Admission diagnosis:	Fever and headache of undetermined origin, possible bacterial meningitis			
Background	Pertinent medical history:	Mandy's parents have refused all immunizations. She had an ear infection 3 weeks ago. Her cousin died of bacterial meningitis 2 years ago at 5 years of age. Mandy presented to the emergency department complaining of a persistent headache and fever, decreased appetite, irritability, and increasing drowsiness.			
	Pertinent social history:	Lives with parents, 2-year-old brother (Michael), and maternal grandparents.			
	Allergies:	Azithromycin (causes rash)			
	Code status:	Full code			
	Vital signs (most recent):	Time: 1500	T: 102.4 F (39.1 C)	BP: 90/50	P: 98
	Oxygen therapy:	Mode: Room air	LPM:	Not applicable	
	Pain:	Rating: 5	Most recent pain medication:	None	Time: 1500
	Other recent medication:	Acetaminophen 250 mg PO at home at 1100. Ibuprofen 170 mg in the emergency department at 1310 for a temp of 103.2 F (39.6 C). Dexamethasone 2.5 mg IV push at 1555.			
	IVs:	Site: Right hand	Type: Peripheral IV	Assessment: Clean, dry, patent	Fluid: Dextrose 5% in 1/2 normal saline with 20 mEq potassium chloride per 1000 mL at 56 mL/hr
	Drains and tubes:	Site: None	Type: Not applicable	Assessment: Not applicable	
	Wounds:	Site: Lumbar region	Type: Puncture	Assessment: Dry and intact	
	ADLs:	Diet: NPO except medications	Activity: Bed rest until 2000, then bathroom privileges with assistance.		
	Restrictions:	Isolation: Droplet isolation	Fall risk: High fall risk		
	Assessments:	Neurologic:	Drowsy but arousable to verbal and tactile stimuli		
		Cardiac:	Normal sinus rhythm, 3+ radial and dorsalis pedis pulses		
		Respiratory:	Clear throughout		
		GI/GU:	Bowel sounds hypoactive		
Integumentary:		Dry, hot, flushed			
Ortho/Mobility:		Full range of motion			
Psychosocial:		Crying, moderately anxious			
Labs and diagnostics:	Other: While she was in the emergency department, a CT scan and lumbar puncture were completed. Bacterial meningitis is suspected. CT scan was negative. Labs indicate slightly elevated WBCs, otherwise normal.				
Assessment	Nurse's assessment:	Droplet isolation and seizure precautions have been initiated. Mandy is sleepy but awakens easily. She is irritable and reports that her head hurts and that the lights bother her. Her parents are in the room. Her father has been searching the Internet for information about meningitis and has been asking a lot of questions. He is anxious for Mandy to start her antibiotics. I gave her dexamethasone IV five minutes ago, which she tolerated well.			
Recommendation	Plan of care:	Will monitor patient for changes in neurologic status and seizures and await neurologic consult. Plan on MRI with contrast and conscious sedation in AM.			
	Tests/results pending:	Urine culture was collected and blood cultures were drawn. Cerebrospinal fluid analysis results and cultures are pending.			
	Orders pending completion:				
	Other:	The IV antibiotic just arrived. I haven't had time to administer it yet. Please do that right away.			

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Sarah Meyers MD

Allergy: azithromycin

Friday 1530:

Admission:

Patient weight: 37.5 lbs

- 1). Admit to pediatric unit.
- 2). Code status: Full code.
- 3). Droplet isolation.
- 4). Seizure precautions.
- 5). Vital signs every 2 hours, with neuro checks.
- 6). Daily weight.
- 7). NPO except for medications.
- 8). Strict intake and output.
- 9). Bed rest until 2000, then bathroom privileges with assistance.
- 10). Dextrose 5% in 0.5% normal saline with 20 mEq potassium chloride per 1000 mL IV to be infused at 56 mL/hr.
- 11). Acetaminophen 250 mg PR every 6 hours PRN for pain or fever greater than or equal to 102 F (38.9 C).
- 12). Ibuprofen 170 mg PO every 6 hours PRN for fever greater than or equal to 102 F (38.9 C). Stagger dosing with acetaminophen.
- 13). Dexamethasone 2.5 mg IV push every 6 hours, first dose now.
- 14). CefoTAXime 850 mg IV every 6 hours, first dose now.
- 15). MRI without contrast and conscious sedation in AM.
- 16). Neurology consult.
- 17). Complete blood count, basic metabolic panel, liver function tests every AM.

S. Meyers MD – Electronically signed.

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Start	Medication	Dose	Next Sched	History	Associated Data
Stop		Route	Ack/View Ord	Monograph	Assessment
Current Status		Frequency	Adjustment	Co-Sign	Ref Err
XX/XX/XXX X	Claforan cefotaxime 850 mg IVPB in 0.9%NS 25 mL	850 mg < 25 mL >	NOW		
		IVPB	ACK		
Active		Q6 HRS			
XX/XX/XXX X	Decadron dexamethasone 2.5 mg IV Push 10mg/mL	2.5 mg	2155	5 min ago	
		IV Push	ACK		
Active		Q6 HRS			
XX/XX/XXX X	Dextrose 5% in 0.5% Normal Saline with Potassium Chloride 20 mEq/1000 mL (D5 1/2NS with 20 mEq KCL/1000 mL)	56 ml/hr	SCH	30 min ago	
		IV	ACK		
Active		CONT			
XX/XX/XXX X	Acetaminophen Tylenol 250MG/SUPPOSITORY	250 mg	PRN	5 HRS ago	
		PR	ACK		
Active		Q6 HRS PRN Temp > 102F or Pain			
XX/XX/XXX X	Ibuprofen 170 mg Oral suspension 120mg/4 mL	170 mg	PRN	3 HRS ago	
		PO	ACK		
Active		Q6HRS PRN Temp >102F			

Emergency Department

Patient name: Mandy Rhodes
 Age: 4
 Birth Day: 9-Sep
 Gender: Female
 Arrival Day: Friday
 Arrival Time: 1300
 Mode of arrival: Walk-in, ambulatory
 Referring facility: Home

Chief Complaint: Fever and headache
 Temperature: 103.2 F (39.6 C)
 Pulse: 108
 Blood Pressure: 94/54
 Weight: 17 kg
 DTaP:
 Respirations: 26

Initial Assessment: Parents report that patient awoke at 0600 with fever and headache. Parents became concerned and brought her to the emergency department for evaluation. Patient is sleepy but arousable; knows her name and where she is. Slightly irritable. Holding her head, stating that it "feels big." Eyes are closed. Purposeful movement of all extremities. Patient has history of recent ear infection.

Care Prior to Arrival: Fever management by family
 Medical History:

Medication	Dosage	Frequency	Last Dose	Allergies	Reaction
Acetaminophen	250 mg	1 time at 1100		Azithromycin	causes rash

Time	Temperature	Blood Pressure	Pulse	Respirations	Pain		
					Time	Scale	Rating
1455	102.9 F (39.4 C)	92/48"	92	26	1455	FACES	5
1420	102.6 F (39.2 C)	94/50"	92	22	1420	FACES	4
1330	103 F (39.4 C)	98/52"	112	28	1330	FACES	5
1303	103.2 F (39.6 C)	94/54"	108	26	1303	FACES	5
						Select one...	

Time	Mode	% or FIO ₂	Pupils			Glasgow Coma		
			Left (mm)	Right (mm)	Time	Score		
1455	Select one...	98	6	6	1455		14	
1420	Select one...	99	7	7	1420		14	
1330	Select one...	99	6	6	1330		14	

1303	Select one... Select one...	99	Select one... Select one...	1303	Select one... Select one...	14
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Primary Diagnosis:

Secondary Diagnosis:

Disposition:

Systems Review
Neurological

Orientation: Person Time Place N/A

Emotional Status: Cooperative Anxious Alert Quiet

Moving All Extremities: Neurological Vital Signs Record:

Cardiovascular

Pulse: Strong Weak Regular Irregular Monitor

Capillary Refill: Less than 2 seconds Less than 4 seconds Greater than 4 seconds

Edema: None 1+ 2+ 3+ 4+

Rhythm: None

Location:

Peripheral pulses

Location: Radial Pedal

Respiratory

Effort:

Breath Sounds:

<input checked="" type="checkbox"/> Clear bilaterally	<input type="checkbox"/> Clear right
<input type="checkbox"/> Diminished bilaterally	<input type="checkbox"/> Diminished right
<input type="checkbox"/> Wheeze right	<input type="checkbox"/> Wheeze left
<input type="checkbox"/> Crackles right	<input type="checkbox"/> Crackles left
<input type="checkbox"/> Rhonchi right	<input type="checkbox"/> Rhonchi left
<input type="checkbox"/> Grunting	<input type="checkbox"/> Retractions

Integumentary

Skin:

Turgor: Mucous Membranes: Anterior Fontanel:

Gastrointestinal

Abdomen: Not applicable Soft Rigid Flat Distended Tender

Bowel Sounds: Describe:

Chest		
Pelvis		
CT of: head, without contrast	1345	1410
Other:		

ED Nurse's Notes		Time	Note	Nurse
Day	Friday	1455	Report given to Susan Simmons, RN on pediatric unit. Transferred to pediatric unit.	S Todd, RN
Friday	Friday	1420	Lumbar puncture completed; patient states that headache is a little better. Still sleepy, falls asleep easily between sentences. Patient positioned on back. Patient and parents instructed on bedrest.	S Todd, RN
Friday	Friday	1410	Back from CT scan; patient remains sleepy but awakens in response to name. Consent for lumbar puncture obtained.	S Todd, RN
Friday	Friday	1345	To CT scan, accompanied by parents; patient remains drowsy but arousable to name.	S Todd, RN
Friday	Friday	1330	EMLA cream applied to lumbar area in preparation for lumbar puncture.	S Todd, RN
Friday	Friday	1310	22-gauge IV placed in right hand with one attempt; positive blood return. Specimens for blood cultures and other bloodwork drawn and sent. IV fluid dextrose 5% in 1/2 normal saline with 20 mEq potassium chloride per 1000 mL Initiated at 56 mL/hr, per order. Catheterized using sterile technique. Specimens for urinalysis and urine culture and specificity sent.	S Todd, RN
Friday	Friday	1310	Ibuprofen 170 mg PO administered for increased temperature.	S Todd, RN
Friday	Friday	1300	Patient admitted to emergency department. Patient is drowsy but arousable to name and tactile stimuli. Skin flushed. Parents at bedside.	S Todd, RN

ED Physician's Notes		Time	Note	Physician
Day	Friday	1420	Lumbar puncture performed, atraumatic. Plan to start cefotaxime 200 mg/kg/day IV (850 mg IV every 6 hours).	W Quicksilver, MD
Friday	Friday	1410	CT results unremarkable. Plan lumbar puncture.	W Quicksilver, MD
Friday	Friday	1330	Consulted with neurology. Admit patient to pediatric unit.	W Quicksilver, MD
Friday	Friday	1300	4-year-old Caucasian female with remote history of right otitis media 3 weeks before this admission. Fever and headache since 0600, now with oral temperature of 103 F (39.4 C) and increased sleepiness. No rash, vomiting, or diarrhea. No known recent exposure to contagious persons. Positive Brudzinski sign, negative Kernig sign. Glasgow Coma Scale score = 14. No history of immunizations (parental refusal). Suspect Haemophilus influenzae type b (Hib). Plan: Admit, blood cultures, labs, urinalysis, urine culture and sensitivity, droplet isolation, CT scan, lumbar puncture, IV fluids, fever management.	W Quicksilver, MD

Provider Signature: Day: Time:

Stool:

Describe:

Last BM:

Genitourinary

Urine Output: Not applicable Normal Increased Decreased Dysuria Increased Blood in urine

Vaginal Bleeding:

Discharge:

Pad per Day:

Reproductive

Pregnant: Not applicable Select one...

If Yes, expected due date:

Fetal activity:

Blood Type:

Rh Factor:

Drug Use

ETOH/Street Drugs/Overdose:

Medications

Time	Medication	Dosage	Mode	Site	Response
1330	EMLA cream	5 g	Topical	Lumbar back	Numbing
1310	Dextrose 5% in 1/2 normal saline with 20 mEq potassium chloride per 1000 mL	56 mL/hr	IV	R hand PIV	Tolerating well
1310	Ibuprofen	170 mg	Oral		Temperature
			Select one...		
			Select one...		

Laboratory

Test	Time Drawn	Time Results
CMP	1310	Pending
Blood Cultures	1310	Pending
Urine CGS, catheterized	1310	Pending
UA, catheterized	1310	Pending
CSF-Gabor	1420	1500 - Cloudy
CSF-WBC	1420	1500 - 248
CSF-RBC	1420	1500 - 0
CSF-Neutrophil	1420	1500 - 85
CSF-Lymphocytes	1420	1500 - 10
CSF-Monocytes	1420	1500 - 5
CSF-Eosinophils	1420	1500 - 0
CSF-Glucose	1420	1500 - 38
CSF-Protein	1420	1500 - 78
CSF-Gram Stain	1420	Pending
CSF-Culture	1420	Pending
CBC	1310	Pending
Lateral C-spine	Film	Time Returned
Complete C-spine		

Emergency Department Laboratory Results

DAY/TIME	Fri 1340
HEMATOLOGY	
White Blood Cell Count	11,600
Red Blood Cell Count	4.78
Hemoglobin	12.6
Hematocrit	39
Mean Corpuscular Volume	82
Platelets	198,000
DIFF: Neutrophil Segs	6308
DIFF: Neutrophil Bands	812
DIFF: Lymphocytes	4200
DIFF: Monocytes	180
DIFF: Eosinophils	100
DIFF: Basophils	0
Reticulocytes	1.0
CHEMISTRY	
Glucose	114
Sodium	137
Potassium	4.6
Chloride	103
Carbon Dioxide	25
Creatinine	0.41
Blood Urea Nitrogen	16
Uric Acid	
Calcium	9.4
Phosphorus	
Magnesium	
Bilirubin (Total)	0.6
Protein (Total)	6.3
Albumin	4.2
Alkaline Phosphatase	280
Alanine Aminotransferase (Formerly Serum Glutamicpyruvic Tranasminase)	40
Aspartate Aminotransferase (Formerly Serum Glutamic- Oxaloacetic Tranaminase)	45
URINE	
Color	Yellow

Clarity	Clear
Glucose	Negative
Bilirubin	Negative
Ketones	1+
Specific Gravity	1.029
Blood	Negative
Hydrogen Ion Concentration	6.0
Protein	Negative
Nitrite	Negative
Leukocytes (Estimated)	Negative
MICRO: White Blood Cell Count	Negative
MICRO: Red Blood Cell Count	Negative
MICRO: Bacteria	Negative
24-HOUR URINE: Total Volume	
24-HOUR URINE: Protein	
24-HOUR URINE: Creatinine	
24-HOUR URINE: Creatinine Clearance	
Epithelial	
SPECIAL TESTS	
Sputum Gram Stain	
Folic Acid	
Blood Cultures x2	Pending



**Radiology
Diagnostic Report**

Diagnostic Report

Department: Pediatric Radiology
Type of Exam: Head CT scan without contrast
Day of Exam: Friday 1345

Report:

The calvarium is intact. The underlying brain parenchyma is normal in appearance, with no extraxial fluid collection, mass, midline shift, or hemorrhage. There is no evidence of cortical-based area of infarction. Gray/white differentiation is preserved. Ventricles and sulci are appropriate for the patient's age, and basal cisterns are patent. The left maxillary sinus is opacified, which is a nonspecific finding. The remainder of the visualized paranasal sinuses and the mastoids are clear.

Impression:

No evidence of acute intracranial pathology. Left maxillary sinus disease. Clinical report given to Dr. William Quicksilver in emergency department.

Recommendation: Consider MRI with/without contrast for further evaluation.

Name (Print): Richard Dense, MD
Signature: Richard Dense, MD