PATIENT CHART

Chart for Millie Larsen Simulation #2

Download these tools and attach to chart:

* Hendrich II Fall Risk Model

<https://hign.org/consultgeri/try-this-series/fall-risk-assessment-older-adults-hendrich-ii-fall-risk-model>

* The Confusion Assessment Method (CAM)

<https://hign.org/consultgeri/try-this-series/confusion-assessment-method-cam>

Add any other relevant information from Simulation 1 chart

SBAR Report Students Will Receive Before Simulation

**Time:** 0700

**Person providing report:** Nurse ending shift

**Situation:** Millie Larsen was brought to the ED by her daughter with confusion. She was diagnosed with a urinary tract infection and dehydration and transferred to our unit yesterday. She had a near fall about 0600 this morning. She said she was trying to go to the bathroom.

**Background:** Prior to admission, Millie’s daughter stopped in to see her at home and found that she was not making sense. She took her to the ED and a decision was made to admit her, but she remained in the ED all night until a bed became available about 0600 yesterday. Mrs. Larsen has a history of hypertension, glaucoma, osteoporosis, arthritis, elevated cholesterol, and stress incontinence. It is unclear whether she has taken her medications properly the past few days, her daughter couldn't tell from looking at her medication box. Her blood pressure was very elevated yesterday, but once we restarted her meds it started coming down.

**Assessment: I** checked her over from head to toe. She says she is OK and has no visible injuries. Her primary care provider and her daughter have been notified. Her daughter is on her way in. She seems less confused as compared to yesterday. Millie’s last vital signs were temperature 98.6, heart rate 78, respirations 14, and her blood pressure is 160/92. She has had 450 cc of amber urine out and she had no pain during the night.

**Recommendation: Please** administer her 0800 medications, do a repeat CAM and a Hendrich II Fall Risk Assessment. Dr. Lund will want those results when he comes in to help him develop a discharge plan.

Progress Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Day 10600 | Admit to medical unit from ED. Start home meds (ordered). I will see patient later this AM. Eric Lund MD |
| Day 11100 | BP at 0700 was 200/110. Patient had likely missed home meds, was confused with UTI. BP decreased in the morning after meds were given. Will keep overnight and continue antibiotics. Eric Lund, MD |
| Day 20800 | Patient had near fall this AM but no injuries reported. BP improved on meds. Taking oral fluids, voiding, no pain. Confusion resolved. Plan to continue taking antibiotics and discharge tomorrow. Family discussing discharge plans. Eric Lund MD |

Nursing Notes

|  |  |
| --- | --- |
| **Date/Time:** |  |
| Day 2 | Pt out of bed this morning, slipped, almost fell. No visible injuries noted. PCP and daughter notified. On all antihypertensives now, BP has improved since admission.C. Roberts, RN |

Medication Administration Record

Scheduled & Routine Drugs

**Allergies/Sensitivities:** None known

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date of Administration** | **Time of Administration:** | **Initials** |
| Day 2(Today) | Captopril | 25 mg | po | three times a day |  |  080012001600 |  |
|  | Metoprolol | 100 mg | po | every day |  | 0800 |  |
|  | Furosemide | 40 mg | po | twice per day |  | 08001600 |  |
|  | Atorvastatin | 50 mg | po | once daily |  | 1600 |  |
|  | Pilocarpine 2% eye drops | 2 drops each eye |  | Twice daily |  | 08002000 |  |
|  | Alendronate | 70 mg | po | weekly | PATIENT TAKES ON SUNDAYS ONLY | 0800 |  |
|  | Ciprofloxacin | 250 mg |  | every 12 hours |  | 08002000 |  |
|  | Celecoxib | 200 mg | po | once a day |  | 0800 |  |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
|  |  |  |  |

PRN and STAT Medications

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date of Order:** | **Medication:** | **Dosage:** | **Route:** | **Frequency:** | **Date/Time Administered:** | **Initials** |
| Day 1 | Acetaminophen | 325 mg | po | every 6 hours as needed for pain |  |  |  |

Nurse Signatures

|  |  |  |  |
| --- | --- | --- | --- |
| **Initial** | **Nurse Signature** | **Initial** | **Nurse Signature** |
| *BL* | Bobbi Lander, RN | *SW* | Steve Witt, RN |

Vital Signs Record

|  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | Day 1 |  |  |  |  |  |  |  |  |  |
| **Time:** | 0045 | 0230 | 0600 | 0700 | 0730 | 0745 | 0800 | 1200 | 1600 | 2010 |
| **Temperature:** | 98.4 | 98.0 | 98.0 | 98.4 |  |  |  | 98.8 | 98.0 | 98.0 |
| **Heart Rate/Pulse:** | 78 | 82 | 80 | 80 |  |  |  | 72 | 82 | 80 |
| **Respirations:** | 14 | 12 | 16 | 16 |  |  |  | 14 | 12 | 16 |
| **Blood Pressure** | 162/88 | 170/90 | 170/90 | 200/110 | 188/98 | 178/90 | 168/80 | 166/88 |  160/86 | 168/88 |
| **O2  Saturation:** | 95% | 94% | 96% | 96% |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |  |
| **Nurse Initials:** | *BT* | *BT* | *CR* | *BL* | *BL* | *BL* | *BL* | *BL* | *BL* | *SW* |
|  |  |  |  |  |  |  |  |  |  |  |

Vital Signs Record

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Date:** | Day 2 |  |  |  |  |  |  |  |  |
| **Time:** | 0015 | 0415 |  |  |  |  |  |  |  |
| **Temperature:** | 98.4 |  |  |  |  |  |  |  |  |
| **Heart Rate/Pulse:** | 80 |  |  |  |  |  |  |  |  |
| **Respirations:** |  |  |  |  |  |  |  |  |  |
| **Blood Pressure** | 166/80 | 168/88 |  |  |  |  |  |  |  |
| **O2  Saturation:** |  |  |  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |  |  |  |
| **Nurse Initials:** | *SW* | *SW* |  |  |  |  |  |  |  |