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THE STATE OF SOUTH CAROLINA
In The Court of Appeals

SC Court of Appeals

APPEAL FROM SOUTH CAROLINA
Workers' Compensation Commission

Appellate Case No.: 2014-002354

Hector G. Fragosa, Claimant,

Appellant,

v.

Kade Construction, LLC, Employer, and Key Risk Insurance Company of S.C., Carrier, Defendants,

Respondents.

RECORD ON APPEAL

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Volume I

INDEX

I. ORDERS 1

Decision and Order of June 28, 2011 1

Appellate Panel Decision and Order of March 19, 2012 14

Opinion No. 5185 of October 10, 2013 23

Order filed March 31, 2014 31

Order of July 24, 2014 32

Remittitur of August 2, 2014 33

Decision and Order of the Appellate Panel filed September 30, 2014 34

II. PLEADINGS 44

Form 21 of March 25, 2011 44

Form 50 of April 8, 2011 45

Form 51 of April 19, 2011 46

Form 58 (Claimant) of May 11, 2011 47

Claimant's APA Submissions 48

No. 1 – MUSC Medical Center 48

No. 2 – MUSC Therapeutic Services 467

No. 3 – MUSC McLennan Banks 626

No. 4 – MUSC Neurology Clinic 699

No. 5 – MUSC ENT Clinic 703

No. 6 – Strand Regional Specialty Associates 715

No. 7 – Atlantic Physical Therapy 777

Claimant's APA Exhibits 892

A – Deposition Transcript of Dr. George Sandoz 892

B – Psychological and Vocational Evaluation by Dr. Robert Brabham 915

C. – Medical Questionnaire from Dr. George Sandoz.....929

Defendants' APA Submissions.....930

No. 6 – Dr. Christian Minshall.....930

No. 7 – Dr. Keith Merrell.....933

No. 8 – Dr. Mark Wagner.....951

No. 9 – Dr. George Sandoz.....957

No. 10 – Dr. Christopher Moses.....981

No. 11 – Dr. John Glasser.....983

No. 12 – Dr. Mark Hoy.....984

No. 13 – Dr. Shane Wolfe.....985

Brief of Appellant of March 25, 2013.....987

Reply Brief of Appellant of March 25, 2013.....1011

Respondents' Final Brief of April 15, 2013.....1025

Petition for Rehearing and Petition for Rehearing En Banc of December 12, 2013.....1047

Appellant's Reply to Respondents' Return to Petition for Rehearing and Petition for Rehearing En Banc of December 31, 2013.....1055

Petition for a Writ of Certiorari of April 29, 2014.....1059

III. TRANSCRIPTS.....1076

Deposition of George M. Sandoz, MD of August 6, 2010.....1076

Caption.....1076

Stipulations.....1078

Examination by Mr. Burkett.....1078

Examination by Mr. Chandler.....1091

Re-examination by Mr. Burkett.....1094

SC Workers' Compensation Commission Hearing of Hector Gomez Fragoso vs Kade Construction, LLC of June 28, 2011.....1098

Caption.....1098

Stipulations 1101
Mr. Fragoso for Claimant 1122
Direct Examination by Mr. Chandler 1123
Cross Examination by Ms. Burkett 1145
Full Commission Hearing, Panel B of March 19, 2012 1148
Caption 1148
Argument by Mr. Samuels 1150
Argument by Mr. Burkett 1158
Reply by Mr. Samuels 1164
IV. CERTIFICATE OF COUNSEL 1168

DECISION AND ORDER OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0717624

Hector G. Fragosa, Employee, Claimant, vs. Kade Construction, LLC, Employer, and Key Risk Management Services, Inc., Carrier, Defendants.	**DECISION AND ORDER**

HEARING:	Held in Conway, South Carolina on June 28, 2011.
APPEARANCES:	Claimant represented by Jeffrey C. Chandler, Esquire of Myrtle Beach, South Carolina. Defendants represented by Michael W. Burkett, Esquire of Willson Jones Carter & Baxley, P.A., Columbia, South Carolina.
PURPOSE OF HEARING:	To determine the issues as set forth on the Forms 50 and 51.
DECISION AND ORDER:	**By: Avery B. Wilkerson, Jr., Commissioner**
FILED:	November 21, 2011

I. APA SUBMISSIONS

Under the Administrative Procedures Act, the following records were submitted into evidence at the time of the hearing:

Claimant's APA Submissions

APA #1: Records of MUSC Medical Center, dated 11/1/2007 – 12/1/2007, consisting of pages 1 – 419.

APA #2: Records of MUSC Therapeutic Services, dated 11/23/2007 – 12/1/2007, consisting of pages 420 – 578.

APA #3: Records of MUSC Department of Orthopaedic Surgery, dated 11/1/2007 – 12/30/2009, consisting of pages 579 – 651.

APA #4: Records of MUSC Neurology, dated 10/30/2008 – 11/4/2008, consisting of pages 652 – 655.

APA #5: Records of MUSC Otolaryngology – Head and Neck Surgery, dated 1/12/2009 – 4/13/2009, consisting of pages 656 – 666.

APA #6: Records of Strand Regional Specialty Associates, LLC, dated 8/29/2008 – 1/19/2011, consisting of pages 667 – 729.

APA #7: Records of Atlantic Physical Therapy & Rehabilitation, Inc., dated 12/16/2008 – 8/31/2009, consisting of pages 730 – 844.

APA Exh. A: Deposition of George M. Sandoz, M.D., dated August 6, 2010, consisting of pages 845 – 867.

APA Exh. B: Psychological and Vocational Evaluation performed by Robert E. Brabham, MRC, CRC, dated November 2, 2010, consisting of pages 868 – 881.

APA Exh. C: Letter from Jeffrey C. Chandler to Dr. Sandoz, dated March 10, 2011, consisting of page 882.

II. STIPULATIONS

Counsel for the respective parties stipulated at the time of the hearing to the following issues:

1. The purpose of the hearing is to determine the issues as set forth in the Forms 50

and 51 and any other issues which may timely come before the Commission;

2. The Claimant's accident occurred on November 1, 2007;

3. The Claimant's average weekly wage was $400.00 with a corresponding compensation rate of $266.68;

4. Notices were timely and properly served upon all parties of interest;

5. Venue, set in Horry County, is proper as agreed by all parties;

6. The South Carolina Workers' Compensation Commission has jurisdiction over the parties and issues involved;

7. The issues for determination are to what extent, if any, the Claimant is entitled to additional compensation benefits for permanent total disability to the injured body parts, and whether the Claimant sustained a physical brain injury as contemplated by § 42-9-10.

Without objection, the Commission's file was made a part of the record in this matter with the exception of any self-serving declaration or unstipulated medical reports.

III. STATEMENT OF THE CASE

The Claimant contends he sustained a work-related injury to his brain, headaches, vision, spine, both upper extremities, left shoulder, hips, both lower extremities, right foot and psychological overlay on November 1, 2007. The Claimant filed a Form 50 on April 8, 2011 requesting compensation for past medical care, future medical treatment, and permanent total disability, and seeking lifetime benefits for physical brain damage.

On April 19, 2011, Defendants timely filed a Form 51 admitting that the Claimant sustained a work injury by accident arising out of or in the course of his employment on November 1, 2007, but denying that the Claimant sustained compensable injuries to the extent alleged in the Claimant's Form 50. Defendants also sought credit for temporary total benefits paid in excess of the award and sought to stop payment of the Claimant's benefits pursuant to the Form 21 filed by the Defendants on March 25, 2011. A hearing was held by the undersigned Commissioner in

Conway, South Carolina on June 28, 2011 to determine the issues raised in the Forms 50, 51 and 21.

It is the Claimant's position in this matter that the Claimant is entitled to additional medical care as a result of his admitted work accident and that he is totally and permanently disabled based on the totality of his injuries. The Claimant also seeks lifetime benefits claiming that he suffered a physical brain injury pursuant to S.C. Code Ann. § 42-9-10.

It is the Defendants' position in this matter that the Claimant is not totally and permanently disabled, and that the Defendants are entitled to stop payment of the Claimant's benefits because the Claimant has reached maximum medical improvement. Defendants contend that the Claimant did not suffer a physical brain injury as defined by S.C. Code Ann. § 42-9-10, and that any alleged injury to the Claimant's brain properly falls under Regulation 67-1101 of the South Carolina Workers' Compensation Commission. The Defendants contend the Claimant is therefore not entitled to lifetime benefits and is not totally and permanently disabled.

IV. EVIDENCE OF THE CASE

The Workers' Compensation Commission's file and Commissioner's notes were made a part of the record of the case.

The Claimant testified at the hearing in this matter, and his testimony allowed the Commissioner to observe the Claimant, to ask questions to the Claimant and to judge the Claimant's credibility as a witness. The Claimant testified that he is thirty (30) years old. The Claimant testified that he is unmarried and has no children, that he was born on October 4, 1980, and that his education background consists of completing middle school in his home country of Mexico. The Claimant testified that he came to the United States in the year of 2002 or 2003, and he speaks very little English. The Claimant's prior work history includes security work, retail sales

and construction. At the hearing, the Claimant described the occurrence of his work injury and the course of his medical treatment. In addition, the Claimant testified regarding his symptoms and the difficulties he still experiences as a result of his injury. The Claimant testified that he has headaches at least once a week and has short term memory problems and dizziness, but he testified that he is still able to drive a car. The Claimant testified that he did not have any brain problems prior to his 2007.

The medical records from the Medical University of South Carolina (MUSC) Medical Center indicate that the Claimant's injuries included subdural and epidural hematomas, bilateral frontal contusions, respiratory failure, hypotension, a scalp laceration, C7 and T1 spinous process fractures, right rib fractures, bilateral transverse fractures, a right big toe fracture, a right fifth toe fracture, a fracture of the skull, a tracheostomy, an endoscopic gastrostomy and an amputation of the second through the fifth toes of the right foot. A CT scan of the Claimant's head performed on the date of the accident revealed a fracture of the skull with a small extraocciptoparietal hematoma and the possibility of a small epidural hematoma.

The medical records from MUSC Therapeutic Services indicate that the Claimant was transferred and admitted for physical therapy on November 23, 2007. The Claimant underwent physical therapy for his toe amputation and was discharged home from MUSC Medical Center by Dr. Christian T. Minshall on December 1, 2007.

The Claimant was readmitted to MUSC Medical Center on December 12, 2007 for an infection to the amputation site at the second through fifth toes of his right foot. The Claimant underwent wound dehiscence and was discharged on December 15, 2007. The MUSC records indicate that the Claimant continued to have follow-up visits at MUSC Medical Center until February 8, 2010.

Dr. Christopher Merrell of MUSC Department of Orthopaedic Surgery saw the Claimant on February 4, 2009 and treated the Claimant for pain in his cervical spine. Dr. Merrell performed a nerve root block on the Claimant's left cervical spine at the C5 region on August 26, 2009 after an MRI revealed neuroforaminal narrowing on the left side. (Claimant's APA #3, pg. 641). Dr. Merrell completed a Form 14B on February 8, 2010 and indicated that the Claimant had sustained an eleven percent (11%) medical impairment to the whole person on account of his cervical spine injury and that the Claimant reached maximum medical improvement on December 30, 2009. Id. at 651.

Dr. Shane Wolfe of MUSC Department of Orthopaedic Surgery treated the Claimant from December 1, 2008 until June 29, 2009 for pain in the Claimant's left shoulder and right foot. Dr. Wolfe prescribed a special foot insert for the Claimant on March 16, 2009 in order to lower the dorsal impact at the site of the Claimant's toe amputation. Id. at 629. Dr. Wolfe completed a Form 14B on February 24, 2010 in which he indicated the Claimant sustained a one percent (1%) impairment to the left upper extremity and could return to work without restriction. Id. at 649. Dr. Wolfe completed another Form 14B on April 8, 2010 in which he indicated that the Claimant sustained a forty percent (40%) impairment rating to the right lower extremity and a one percent (1%) impairment rating to the left upper extremity. Id. at 650. Dr. Wolfe further indicated that the Claimant had a combined impairment rating of seventeen percent (17%) to the whole person on account of the Claimant's right foot and left shoulder injuries. Id.

Dr. Wolfe referred the Claimant to Atlantic Physical Therapy & Rehabilitation, Inc. for physical therapy. The Claimant regularly underwent physical therapy for his cervical and left shoulder pain from December 16, 2008 until August 31, 2009. (Claimant's APA #7).

Dr. Mark Wagner, a Clinical Neuropsychologist, saw the Claimant on October 30, 2008

and completed an independent medical evaluation. Dr. Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but concluded that functional studies, such as EEGs, CTs and MRIs, were read as unremarkable "demonstrating structural resolution of the work-related injury." (Claimant's APA #4, pg. 655).

Dr. Mark Hoy of MUSC Department of Otolaryngology – Head and Neck Surgery treated the Claimant from December 1, 2008 until April 13, 2009 for ear pain associated with the Claimant's closed head injury. Despite the Claimant's continued complaints of ear pain, Dr. Hoy noted most of the Claimant's tests to be normal and opined in a Form 14B on March 16, 2010 that the Claimant reached maximum medical improvement with regard to his ear pain on April 13, 2009 and that the Claimant would not need future medical care with regard to his ear pain. (Claimant's APA #5, pg. 666). Dr. Hoy did not give the Claimant any impairment rating in the Form 14B, but placed a question mark ("?") in the blank space where the impairment rating is to be written. Id.

Dr. George M. Sandoz of Strand Regional Specialty Associates, LLC initially treated the Claimant for dizziness and headaches from August 29, 2008 to August 12, 2009. Dr. Sandoz also noted that the Claimant had some damage to his right inner ear which had caused some loss of hearing and mastoiditis. (Deposition of George M. Sandoz, Claimant's APA Exhibit A, pg. 852-853, pg. 865-866). Dr. Sandoz described mastoiditis as an inflammation of the mastoid, which is a part of the skull, not of the brain. Id. at 865-866. On August 20, 2009, Dr. Sandoz drafted a letter stating that the Claimant had a forty-six percent (46%) impairment to the whole body for a traumatic brain injury. (Claimant's APA #6, pg. 716). Dr. Sandoz went on to state in this letter that the Claimant is totally and permanently disabled. Id. Dr. Sandoz reaffirmed this position in his August 6, 2010 deposition, stating that the Claimant is not able to return to any kind of former

employment due to an inability to follow commands and to the inner ear injury which causes the Claimant to be unsteady and dizzy. (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, pg. 863). Dr. Sandoz also stated in his deposition that the Claimant suffered some damage and injury to the function of the brain. Id. at 859.

Despite Dr. Sandoz's opinion that the Claimant suffered a traumatic brain injury, Dr. Sandoz stated at his deposition that "There's no evidence of any damage on the brain that we can go and see." Id. at 859. The Claimant's medical record is void of any neurological medical treatment from August 12, 2009 through August 6, 2010, the date of Dr. Sandoz's deposition. Dr. Sandoz did not treat the Claimant from August 12, 2009 until November 12, 2010. Despite the Claimant's lack of treatment for over a year and Dr. Sandoz's statement that there was no visible physical damage to the Claimant's brain, Dr. Sandoz concluded the Claimant was totally and permanently disabled on account of a physical brain injury in a letter dated March 17, 2011. (Claimant's APA Exhibit C, pg. 882). This letter was sent by the Claimant's attorney to Dr. Sandoz with the option of circling either "YES" or "NO" with respect to the Claimant's suffering a physical brain injury which renders him totally and permanently disabled. Id.

The Claimant was seen on October 27, 2010 for a Psychological and Vocational Evaluation by Robert E. Brabham, MRC, CRC. In Dr. Brabham's November 2, 2010 report, he concluded that the Claimant has a physical brain injury and must be expected to permanently remain unable to engage in full-time gainful employment. (Claimant's APA Exhibit B). Dr. Brabham diagnosed the Claimant with cognitive disorder secondary to "(physical) traumatic brain injury." Id. at 879. Dr. Brabham further concluded that the Claimant's brain injury and restrictions were the result of his November 1, 2007 work-related injury.

A record such as was necessary for a decision was made of the proceeding and after careful

consideration and study of all the evidence, the following findings of fact are accordingly made.

V. FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Hector G. Fragosa as Employee-Claimant and Kade Construction, LLC as Employer and Key Risk Management Services, Inc. as Carrier, Defendants.

2. That the average weekly wage of Employee-Claimant at the time of the above-described accident was $400.00, with an applicable compensation rate was $266.68.

3. That the Claimant testified that he was twenty-nine (29) years old, was not married, and has no children. The Claimant's date of birth is October 4, 1980 and his age is thirty (30) years old.

4. That this is a closed head injury.

5. That the Claimant came from Mexico to the United States in 2002 or 2003. He went to middle school. He speaks very little English. The Claimant has worked in the construction industry his whole life. The Claimant did not have problems with his brain prior to the 2007 accident. He has headaches at least once a week and has short term memory problems. The Claimant is constantly dizzy.

6. That the Claimant sustained an eleven percent (11%) medical impairment to the whole person on account of his cervical spine injury as stated by Dr. Christopher Merrell in his February 8, 2010 Form 14B.

7. That the Claimant sustained a forty percent (40%) impairment rating to the right lower extremity and a one percent (1%) impairment rating to the left upper extremity, and had a

combined impairment rating of seventeen percent (17%) to the whole person on account of the Claimant's right foot and left shoulder injuries as stated by Dr. Shane Wolfe in his April 8, 2010 Form 14B.

8. That the Claimant sustained a forty-six percent (46%) impairment to the whole person for a traumatic brain injury as stated by Dr. George M. Sandoz in his August 20, 2009 letter. (Claimant's APA #6, pg. 716).

9. That, after considering the Claimant's multiple impairment ratings, the Claimant is permanently and totally disabled and is unable to return to any type of work that he has performed in the past.

10. That the ratings themselves would exceed the five hundred (500) weeks after applying all the factors, age, education and work restrictions as well as the disfigurements noted in the record.

11. That Dr. George M. Sandoz testified in his deposition on August 6, 2010 that the Claimant was disabled on account of a traumatic brain injury. (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 858). There is no neurological medical treatment from August of 2009 to November of 2010 indicating that this is the case.

12. That Dr. Mark Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but Dr. Wagner concluded that functional studies, such as EEGs, CTs and MRIs, were read as unremarkable "demonstrating structural resolution of the work-related injury." (Claimant's APA #4, pg. 655).

13. That Dr. Mark Wagner noted on October 30, 2008 that the Claimant suffers from mild post-concussive syndrome. (Claimant's APA Exhibit B, p. 874).

14. That Dr. George M. Sandoz testified that the Claimant suffers from mastoiditis

"and that's why he's dizzy." (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 861).

15. That Dr. Shane Wolfe prescribed a special foot insert for the Claimant on March 16, 2009 in order to lower the dorsal impact at the site of the Claimant's toe amputation. (Claimant's APA #3, pg. 629).

16. That Dr. Christopher Merrell performed a nerve root block on the Claimant's left cervical spine at the C5 region on August 26, 2009 after an MRI revealed neuroforaminal narrowing on the left side. (Claimant's APA #3, pg. 641).

17. That there has been no Guardian *ad Litem* appointed on the Claimant's behalf.

18. That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply.

VI. CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-40, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-9-30 and Reg. 67-1101, the Claimant's multiple impairment ratings to his right lower extremity, left upper extremity, head and inner ear render the Claimant permanently and totally disabled.

3. Under § 42-9-30 and § 42-9-10, the Claimant has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers'

Compensation Act.

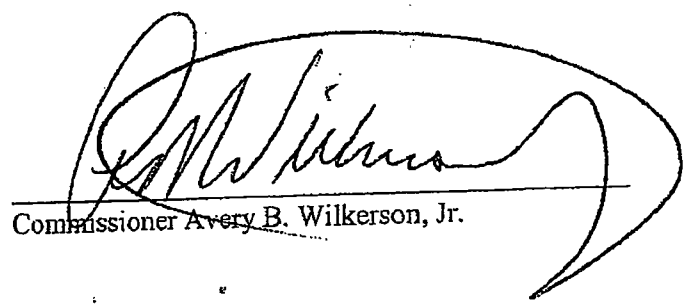
VII. ORDER/AWARD

IT IS HEREBY ORDERED that the Defendants shall pay the Claimant compensation benefits for permanent total disability as set forth in the Conclusions of Law above.

IT IS SO ORDERED.

ORDER REQUESTED ON JULY 20, 2011.

SOUTH CAROLINA WORKERS'
COMPENSATION COMMISSION



Commissioner Avery B. Wilkerson, Jr.

CERTIFICATE OF SERVICE

This is to certify the undersigned has this date served this order in the above entitled action upon all parties to this cause by sending an electronic copy hereof by electronic mail addressed to the attorney or attorneys for said parties or by depositing a copy hereof, postage paid, in the United States certified mail addressed to any unrepresented party.

November 21, 2011

By: Elaine Boyd, Administrative Assistant to Commissioner Wilkerson

APPELLATE PANEL
DECISION AND ORDER
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION
WCC FILE NO.: 0717624

Hector G. Fragosa,
Employee/Claimant,
Appellant

vs.

Kade Construction, LLC
Employer,

and

Key Risk Management Services, Inc.,
Carrier,
Defendants,
Respondents.

Appellate Panel Review held in Columbia, South Carolina on March 19, 2012 per Notices timely and properly served on all parties of interest.

Appellate Panel Decision and Order filed 5/23, 2012.

Appearances: Claimant/Appellant represented by Stephen B. Samuels, Esquire, of the Samuels Law Firm, 1527 Blanding Street, Columbia, SC 29201

Defendants/Respondents represented by Michael W. Burkett, Esquire, of Willson, Jones, Carter & Baxley, 4500 Ft. Jackson Blvd., Columbia, SC 29209.

STATEMENT OF THE CASE

The parties were heard by Commissioner Avery B. Wilkerson on June 28, 2011 in Conway, South Carolina. As a result of said hearing, Commissioner Wilkerson issued an Order dated November 21, 2011, from which the Claimant appealed.

The Hearing Commissioner's Decision and Order set forth the following Findings of Fact:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Hector G. Fragosa as Employee-Claimant and Kade Construction, LLC as Employer and Key Risk Management Services, Inc. as Carrier, Defendants.

2. That the average weekly wage of Employee-Claimant at the time of the above-described accident was $400.00, with an applicable compensation rate was $266.68.

3. That the Claimant testified that he was twenty-nine (29) years old, was not married, and has no children. The Claimant's date of birth is October 4, 1980 and his age is thirty (30) years old.

4. That this is a closed head injury.

5. That the Claimant came from Mexico to the United States in 2002 or 2003. He went to middle school. He speaks very little English. The Claimant has worked in the construction industry his whole life. The Claimant did not have problems with his brain prior to the 2007 accident. He has headaches at least once a week and has short term memory problems. The Claimant is constantly dizzy.

6. That the Claimant sustained an eleven percent (11%) medical impairment to the whole person on account of his cervical spine injury as stated by Dr. Christopher Merrell in his

February 8, 2010 Form 14B.

7. That the Claimant sustained a forty percent (40%) impairment rating to the right lower extremity and a one percent (1%) impairment rating to the left upper extremity, and had a combined impairment rating of seventeen percent (17%) to the whole person on account of the Claimant's right foot and left shoulder injuries as stated by Dr. Shane Wolfe in his April 8, 2010 Form 14B.

8. That the Claimant sustained a forty-six percent (46%) impairment to the whole person for a traumatic brain injury as stated by Dr. George M. Sandoz in his August 20, 2009 letter. (Claimant's APA #6, pg. 716).

9. That, after considering the Claimant's multiple impairment ratings, the Claimant is permanently and totally disabled and is unable to return to any type of work that he has performed in the past.

10. That the ratings themselves would exceed the five hundred (500) weeks after applying all the factors, age, education and work restrictions as well as the disfigurements noted in the record.

11. That Dr. George M. Sandoz testified in his deposition on August 6, 2010 that the Claimant was disabled on account of a traumatic brain injury. (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 858). There is no neurological medical treatment from August of 2009 to November of 2010 indicating that this is the case.

12. That Dr. Mark Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but Dr. Wagner concluded that functional studies, such as EEGs, CTs and MRIs, were read as unremarkable "demonstrating structural resolution of the work-related injury." (Claimant's APA #4, pg. 655).

13. That Dr. Mark Wagner noted on October 30, 2008 that the Claimant suffers from mild post-concussive syndrome. (Claimant's APA Exhibit B, p. 874).

14. That Dr. George M. Sandoz testified that the Claimant suffers from mastoiditis "and that's why he's dizzy." (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 861).

15. That Dr. Shane Wolfe prescribed a special foot insert for the Claimant on March 16, 2009 in order to lower the dorsal impact at the site of the Claimant's toe amputation. (Claimant's APA #3, pg. 629).

16. That Dr. Christopher Merrell performed a nerve root block on the Claimant's left cervical spine at the C5 region on August 26, 2009 after an MRI revealed neuroforaminal narrowing on the left side. (Claimant's APA #3, pg. 641).

17. That there has been no Guardian *ad Litem* appointed on the Claimant's behalf.

18. That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply.

The Hearing Commissioner's Decision and Order also set forth the following Conclusions of Law:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-9-30 and Reg. 67-1101, the Claimant's multiple impairment ratings to his right lower extremity, left upper extremity, head and inner ear render the Claimant permanently and totally disabled.

3. Under § 42-9-30 and § 42-9-10, the Claimant has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act.

Within the statutory period, counsel for the Claimant filed an Application for Review in the case setting forth the following assignments of error:

1. Whether the Single Commissioner erred as a matter of fact and law in finding: "That, based on the greater weight of the evidence, I find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10 and physical brain damage does not apply."

2. Whether the Single Commissioner erred as a matter of fact and law in finding that a neuropsychologist was qualified to give an opinion as to whether "functional studies, such as EEGs, CTs and MRIs, were read as unremarkable 'demonstrating structural resolution of the work-related injury'" when a neuropsychologist's expertise does not extend to reading and interpreting EEGs, CTs and MRIs.

3. Whether the Single Commissioner erred as a matter of fact and law in arbitrarily disregarding the unrefuted expert medical opinion of Dr. Sandoz that Claimant had suffered a physical brain injury.

4. Whether the Single Commissioner erred as a matter of fact and law in giving any weight to Dr. Wagner's opinion where the opinion was not stated to a reasonable degree of medical certainty.

5. Whether the Single Commissioner erred as a matter of law in failing to make specific and detailed findings of fact sufficient for appellate review.

6. Whether the Single Commissioner erred as a matter of fact and law in failing to award lifetime compensation to Claimant in that he was totally disabled and had suffered physical brain injury.

Copies of the above assignments of error were furnished to all interested parties prior to oral argument presented before the Appellate Panel on March 19, 2012.

Pursuant to S.C. Code Ann. § 42-17-50 (1985), the Appellate Panel reviewed the Award and weighed the evidence in the record as presented at the initial hearing. The Panel also

considered all issues raised in the brief of the Appellant and Respondents. The Panel makes the following Findings of Fact and Conclusions of Law:

FINDINGS OF FACT

IT IS FOUND AS A FACT:

1. That Employee, Employer, and Carrier are subject to and bound by the terms and provisions of the South Carolina Workers' Compensation Act, as amended, with Hector G. Fragosa as Employee-Claimant and Kade Construction, LLC as Employer and Key Risk Management Services, Inc. as Carrier, Defendants.

2. That the average weekly wage of Employee-Claimant at the time of the above-described accident was $400.00, with an applicable compensation rate was $266.68.

3. That the Claimant testified that he was twenty-nine (29) years old, was not married, and has no children. The Claimant's date of birth is October 4, 1980 and his age is thirty (30) years old.

4. That this is a closed head injury.

5. That the Claimant came from Mexico to the United States in 2002 or 2003. He went to middle school. He speaks very little English. The Claimant has worked in the construction industry his whole life. The Claimant did not have problems with his brain prior to the 2007 accident. He has headaches at least once a week and has short term memory problems. The Claimant is constantly dizzy.

6. That the Claimant sustained an eleven percent (11%) medical impairment to the whole person on account of his cervical spine injury as stated by Dr. Christopher Merrell in his February 8, 2010 Form 14B.

7. That the Claimant sustained a forty percent (40%) impairment rating to the right

lower extremity and a one percent (1%) impairment rating to the left upper extremity, and had a combined impairment rating of seventeen percent (17%) to the whole person on account of the Claimant's right foot and left shoulder injuries as stated by Dr. Shane Wolfe in his April 8, 2010 Form 14B.

8. That the Claimant sustained a forty-six percent (46%) impairment to the whole person for a traumatic brain injury as stated by Dr. George M. Sandoz in his August 20, 2009 letter. (Claimant's APA #6, pg. 716).

9. That, after considering the Claimant's multiple impairment ratings, we find that the Claimant is permanently and totally disabled and is unable to return to any type of work that he has performed in the past.

10. That the ratings themselves would exceed the five hundred (500) weeks after applying all the factors, age, education and work restrictions as well as the disfigurements noted in the record.

11. That Dr. George M. Sandoz testified in his deposition on August 6, 2010 that the Claimant was disabled on account of a traumatic brain injury. (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 858). There is no neurological medical treatment from August of 2009 to November of 2010 indicating that this is the case.

12. That Dr. Mark Wagner noted that the Claimant sustained a skull fracture with acute underlying minor structural change to the brain, but Dr. Wagner concluded that functional studies, such as EEGs, CTs and MRIs, were read as unremarkable "demonstrating structural resolution of the work-related injury." (Claimant's APA #4, pg. 655).

13. That Dr. Mark Wagner noted on October 30, 2008 that the Claimant suffers from mild post-concussive syndrome. (Claimant's APA Exhibit B, p. 874).

14. That Dr. George M. Sandoz testified that the Claimant suffers from mastoiditis "and that's why he's dizzy." (Deposition of George M. Sandoz, M.D., Claimant's APA Exhibit A, p. 861).

15. That Dr. Shane Wolfe prescribed a special foot insert for the Claimant on March 16, 2009 in order to lower the dorsal impact at the site of the Claimant's toe amputation. (Claimant's APA #3, pg. 629).

16. That Dr. Christopher Merrell performed a nerve root block on the Claimant's left cervical spine at the C5 region on August 26, 2009 after an MRI revealed neuroforaminal narrowing on the left side. (Claimant's APA #3, pg. 641).

17. That there has been no Guardian *ad Litem* appointed on the Claimant's behalf.

18. That, based on the greater weight of the evidence, we find there has not been a physical brain injury as it does not meet the criteria established under the South Carolina Workers' Compensation Act. This award is made under § 42-9-30 and § 42-9-10, and physical brain damage does not apply.

CONCLUSIONS OF LAW

Accordingly, as provided in § 42-17-50, SC Code Ann. (1976), as amended, it is the determination of this Commission that:

1. Under § 42-1-130, Claimant was a covered employee at the time in question; and under § 42-1-140, Defendant/Employer was a covered employer under the Act.

2. Under § 42-9-30 and Reg. 67-1101, the Claimant's multiple impairment ratings to his right lower extremity, left upper extremity, head and inner ear render the Claimant permanently and totally disabled.

3. Under § 42-9-30 and § 42-9-10, the Claimant has not suffered a physical brain

injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act.

After careful review in the present case, the Appellate Panel of the South Carolina Workers' Compensation Commission has determined the Order of the Hearing Commissioner is hereby AFFIRMED IN FULL. The Findings of Fact and Conclusions of Law found in the Hearing Commissioner's Decision and Order, and as specified above, are hereby AFFIRMED IN FULL.

ORDER

IT IS HEREBY ORDERED that the Order of the Single Commissioner from which this appeal has been taken is hereby AFFIRMED IN FULL.

IT IS AFFIRMED that the Defendants shall pay the Claimant compensation benefits for permanent total disability as set forth in the Conclusions of Law above.

IT IS AFFIRMED that the Claimant has not suffered a physical brain injury and is not entitled to lifetime compensation benefits under the South Carolina Workers' Compensation Act.

IT IS SO ORDERED.

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

Susan S. Barden, Commissioner
For the Appellate Panel

Concur:

Gene McCaskill, Commissioner

Derrick L. Williams, Commissioner

CERTIFICATE OF SERVICE

This is to certify that the undersigned has this date served this order in the above entitled action upon all parties to this cause by depositing a copy hereof, postage paid, in the United State mail addressed to the attorney or attorneys for said parties.

This 23 day of May, 2012

By Valerie O Beller

Administrative Assistant to the Commissioner

Michael W. Burkett
Jeff C. Chandler
Stephen B. Samuels

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

Hector G. Fragosa, Employee/Claimant, Appellant,

v.

Kade Construction, LLC, Employer, and Key Risk Management Services, Inc., Carrier, Respondents.

Appellate Case No. 2012-212279

Appeal From The Workers' Compensation Commission

Opinion No. 5185
Heard October 10, 2013 – Filed November 27, 2013

AFFIRMED IN PART AND REMANDED

Stephen Benjamin Samuels, of Samuels Law Firm, LLC, of Columbia, and Jeffrey Christopher Chandler, of Chandler Law Firm, of Myrtle Beach, for Appellant.

Michael W. Burkett and John Gabriel Coggiola, both of Willson Jones Carter & Baxley, P.A., of Columbia, for Respondents.

LOCKEMY, J.: Hector Fragosa appeals the South Carolina Workers' Compensation Commission Appellate Panel's (Appellate Panel) order, arguing the Appellate Panel erred in (1) finding he did not suffer physical brain damage, and was thus not entitled to lifetime benefits; and (2) relying on the opinion of Dr. Mark Wagner. We affirm in part and remand.

FACTS/PROCEDURAL BACKGROUND

On November 1, 2007, Fragosa, a construction worker employed by Kade Construction, LLC (Kade), sustained injuries during the course and scope of his employment when he was hit in the head with part of a construction crane and knocked off of the roof of a parking garage. Fragosa was transported by helicopter to MUSC in Charleston and remained in a coma for two weeks following the accident.

Pursuant to his MUSC discharge summary, Fragosa's diagnoses included: subdural and epidural hematomas, bilateral frontal contusions, respiratory failure, hypotension, scalp laceration, C7 and T1 spinous process fractures, right rib fractures, bilateral transverse fractures, right big toe fracture, right fifth toe fracture, skull fracture, tracheostomy, placement of endoscopic gastrostomy, and amputation of the second through fifth toes of the right foot.

Kade accepted Fragosa's claim and began providing benefits. In October 2008, Fragosa was evaluated by Dr. Mark Wagner, a clinical neuropsychologist. Dr. Wagner noted Fragosa sustained a skull fracture with acute underlying minor structural change to the brain, but his functional studies (i.e., EEGs, CTs, and MRIs) were read as "unremarkable" and demonstrated "structural resolution of the work-related injury." Dr. Wagner found Fragosa had "symptoms of mild post-concussive syndrome" and his cognitive deficits were "relatively mild." According to Dr. Wagner, Fragosa was most likely at maximum medical improvement in terms of his neurological status, and the severity of his cognitive deficits was not a major barrier to his return to work.

From October 2008 to August 2009, Fragosa was treated by neurologist Dr. George Sandoz for headaches and dizziness. Dr. Sandoz determined Fragosa had a right temporal lobe injury, but found there was "no evidence of any seizure . . . nor any evidence of any damage of the brain." Dr. Sandoz testified Fragosa had damage to his right inner ear which caused some loss of hearing and mastoiditis. Dr. Sandoz opined Fragosa suffered a traumatic brain injury and was totally and permanently disabled. According to Dr. Sandoz, Fragosa had a 46% impairment rating to the whole body. Dr. Sandoz opined Fragosa would be unable to return to gainful employment "not only because of the traumatic injury" but also because his inner ear injury would make him unsteady on his feet. Dr. Sandoz testified that while Fragosa suffered some damage and injury to the *function* of the brain, "there's no evidence of any damage on the brain that we can go and see." In a March 2011 questionnaire from Fragosa's attorney, Dr. Sandoz checked "Yes" in

response to the question of whether Fragosa suffered physical brain damage rendering him totally and permanently disabled.

In October 2010, Fragosa was evaluated by psychologist and brain injury specialist Dr. Robert Brabham. Dr. Brabham noted Fragosa continued to experience symptoms typically associated with brain injuries including headaches, dizziness, anxiety, depression, and memory loss. Dr. Brabham concluded Fragosa's "behavioral and cognitive changes have persisted . . . sufficient to conclude that the brain injuries he sustained, described as post-concussion injuries in multiple records, has resulted in continuing and severe symptoms clearly associated with a physical traumatic brain injury, the result of his on-the-job injuries." Dr. Brabham further opined "to a high degree of medical certainty . . . [Fragosa] has experienced a (Physical) Traumatic Brain Injury and must be expected to permanently remain, unable to engage in full-time gainful, competitive employment."

On March 21, 2011, Kade and its insurance carrier, Key Risk Management Services, Inc., (collectively, Respondents) filed a Form 21 seeking to terminate temporary compensation. On April 8, 2011, Fragosa filed a Form 50 alleging he was totally and permanently disabled as a result of injuries to his "brain, headaches, vision, spine, both upper extremities, left shoulder, hips, both lower extremities, right foot and psychological overlay." Fragosa also alleged he sustained physical brain damage as a result of the accident. Respondents filed a Form 51 admitting Fragosa sustained a work injury, but denying the extent of the injuries as alleged by Fragosa.

A hearing was held before the Single Commissioner on June 28, 2011. At the hearing, Fragosa alleged he was entitled to additional medical treatment as result of his accident and a finding that he was totally and permanently disabled based on the totality of his injuries. Additionally, Fragosa claimed he suffered physical brain damage pursuant to section 42-9-10(C) of the South Carolina Code (Supp. 2012) and thus, he was entitled to lifetime medical benefits. Respondents argued Fragosa was not totally and permanently disabled and they were entitled to stop payment of Fragosa's temporary benefits because he had reached MMI. Respondents also argued Fragosa did not suffer physical brain damage, and any permanent disability compensation for an alleged injury to Fragosa's brain fell under Regulation 67-1101 of the South Carolina Code of Regulations (2012) which sets forth the range of 25-250 weeks for either partial or total loss of use of the brain as a result of a work accident.

In a November 21, 2011 order, the Single Commissioner held Fragosa's multiple impairment ratings to his right leg, left arm, head and inner ear rendered him totally and permanently disabled. Additionally, the Single Commissioner found Fragosa did not suffer a physical brain injury or physical brain damage, and was not entitled to lifetime medical benefits. Fragosa appealed the Single Commissioner's findings to the Appellate Panel. Following a hearing, the Appellate Panel affirmed the Single Commissioner's order in May 2012. Fragosa appealed.

STANDARD OF REVIEW

The Administrative Procedures Act establishes the standard of review for decisions by the Appellate Panel. *Lark v. Bi-Lo, Inc.*, 276 S.C. 130, 135, 276 S.E.2d 304, 306 (1981). The Appellate Panel is the ultimate fact finder in workers' compensation cases and is not bound by the single commissioner's findings of fact. *Etheredge v. Monsanto Co.*, 349 S.C. 451, 454, 562 S.E.2d 679, 681 (Ct. App. 2002). The findings of the Appellate Panel are presumed correct and will be set aside only if unsupported by substantial evidence. *Lark*, 276 S.C. at 135, 276 S.E.2d at 306. "Substantial evidence is not a mere scintilla of evidence, nor the evidence viewed blindly from one side of the case, but is evidence that, considering the record as a whole, would allow reasonable minds to reach the conclusion the administrative agency reached in order to justify its action." *Taylor v. S.C. Dep't of Motor Vehicles*, 368 S.C. 33, 36, 627 S.E.2d 751, 752 (Ct. App. 2006) (quoting *S.C. Dep't of Motor Vehicles v. Nelson,* 364 S.C. 514, 519, 613 S.E.2d 544, 547 (2005)). "The mere possibility of drawing two inconsistent conclusions from the evidence does not prevent a finding from being supported by substantial evidence." *Olson v. S.C. Dep't of Health & Envtl. Control*, 379 S.C. 57, 63, 663 S.E.2d 497, 501 (Ct. App. 2008).

LAW/ANALYSIS

I. Physical Brain Damage

Fragosa argues the Appellate Panel erred in finding he did not suffer physical brain damage and was not entitled to lifetime medical benefits. We remand.

The nexus of this case is the distinction between a physical brain *injury*, which is compensated pursuant to Regulation 67-1101,[1] and physical brain *damage*, which is compensated pursuant to section 42-9-10(C). Fragosa argues on appeal that the Appellate Panel erred in failing to find he suffered physical brain *damage* and was entitled to lifetime medical benefits. However, throughout his brief Fragosa cites examples to support his position that he suffered a brain *injury*. Respondents do not deny that Fragosa suffered a physical brain *injury*. Instead, they maintain Fragosa failed to show he suffered physical brain *damage*.

In general, a person injured within the Workers' Compensation Act (the Act) may not receive compensation for a period exceeding five hundred weeks. *See* S.C. Code Ann. § 42-9-10(A) (Supp. 2012); S.C. Code Ann. Regs. 67-1101 (2012). However,

> [n]otwithstanding the five-hundred-week limitation prescribed in this section or elsewhere in this title, any person determined to be totally and permanently disabled who as a result of a compensable injury is a paraplegic, a quadriplegic, *or who has suffered physical brain damage* is not subject to the five-hundred-week limitation and shall receive the benefits for life.

---

[1] Section 42-9-30 of the South Carolina Code (Supp. 2012) provides specific recoveries for total or partial physical losses and impairments suffered by an employee to certain scheduled members including: thumbs, fingers, toes, hands, arms, feet, legs, eyes, and ears. This section further provides:

> For the total or partial loss of, or loss of use of, a member, organ, or part of the body *not covered in this section* . . . [t]he Commission, by regulation, shall prescribe the ratio which the partial loss or loss or partial loss of use of a particular member, organ, or body part bears to the whole man, basing these ratios on accepted medical standards and these ratios determine the benefits payable under this subsection.

S.C. Code Ann. § 42-9-30(22) (Supp. 2012) (emphasis added). Regulation 67-1101 provides additional examples of compensable scheduled members, including the brain. It sets forth the range of 25-250 weeks of compensation for either partial loss or loss of use of the brain. S.C. Code Ann. Regs. 67-1101 (2012).

S.C. Code Ann. § 42-9-10(C) (Supp. 2012) (emphasis added). "Physical brain damage" is not statutorily defined. However, our supreme court recently clarified what is meant by "physical brain damage" under section 42-9-10(C) in *Crisp v. SouthCo., Inc.*, 401 S.C. 627, 738 S.E.2d 835 (2013) (*Crisp II*). In *Crisp II*, the court found Crisp's argument that the mere presence of any physical brain injury or damage, regardless of degree, triggered the operation of section 42-9-10(C) was not persuasive. 401 S.C. at 641, 738 S.E.2d at 842. The court viewed

> the inclusion of 'physical brain damage,' along with quadriplegia and paraplegia, in section 42-9-10(C) as indicative of the General Assembly's intent to compensate an employee-claimant for life only in the most serious cases of injury to the brain, separate and apart from other scheduled injuries, resulting in permanent physical brain damage.

Crisp, 401 S.C. at 641-42, 738 S.E.2d at 842. The *Crisp II* court found "the severity of the injury is the lynchpin of the analysis" and interpreted "the inclusion of 'physical brain damage' among the most serious injuries within the statutory exception to the 500 week cap on benefits as an indication that the legislature was contemplating a brain injury so severe that the person could not subsequently return to suitable gainful employment." *Id.* at 643, 738 S.E.2d at 843. The court stated its interpretation of the legislature's intent was "in harmony with the entire purpose of our workers' compensation regime and recognizes the other avenues of compensation available under the scheme for brain injuries that do not render the worker unemployable." *Id.* at 644, 738 S.E.2d at 843. Further, the court noted the question of whether an employee has sustained either a physical brain injury or physical brain damage "gives rise to the coextensive question of what proof is required in these cases." *Id.* at 644, 738 S.E.2d at 844. In light of the testimony, the *Crisp II* court found it was "reluctant to require use of a specific diagnostic tool in proving these medically-technical brain injury cases." *Id.*

Additionally, in *Sparks v. Palmetto Hardwood, Inc.*, Op. No. 27229 (S.C. Sup. Ct. filed May 22, 2013) (Shearouse Ad. Sh. No. 23 at 40), our supreme court declined to impose a requirement that physical brain damage be proven through an "objective diagnostic medium," and concluded that physical brain damage, as described in section 42-9-10(C), is damage that is permanent and severe.

Here, the Appellate Panel made inconsistent findings with regard to the existence of a physical brain injury. In finding of fact #8, the Appellate Panel found Fragosa sustained a forty-six percent impairment to the whole person for a traumatic brain injury. However, in finding of fact #18, the Appellate Panel found Fragosa did not suffer a brain injury. Based on this inconsistency, we remand to the Appellate Panel for clarification. It is undisputed that Fragosa suffered severe injuries as a result of a work related accident. However, it is unclear whether the Appellate Panel found these injuries included an injury to the brain. If the Appellate Panel finds Fragosa did sustain a physical brain injury, it should, in light of *Crisp II* and *Sparks*, cite specific evidence to support its determination as to whether such injury was of sufficient severity to reach the level of physical brain damage as contemplated in section 42-9-10(C).

II. Dr. Wagner

Fragosa argues the Appellate Panel erred in relying on Dr. Wagner's report in finding Fragosa did not suffer physical brain damage. We disagree.

The Appellate Panel found:

> Dr. Mark Wagner noted that [Fragosa] sustained a skull fracture with acute underlying minor structural change to the brain, but Dr. Wagner concluded that functional studies, such as EEGs, CTs, and MRIs, were read as unremarkable 'demonstrating structural resolution of the work-related injury.' ([Fragosa]'s APA #4, pg. 655).

Fragosa contends the Appellate Panel's reliance on Dr. Wagner's statement regarding imaging studies having been read as unremarkable is legal error. He maintains Dr. Wagner never rendered an opinion, or "concluded" as the order states, that Fragosa did not suffer physical brain damage. Instead, Fragosa argues Dr. Wagner merely commented that the later imaging studies were read as unremarkable. Fragosa asserts that as a neuropsychologist, Dr. Wagner cannot interpret imaging studies.

In reply, Respondents argue Dr. Wagner simply restated the findings made by other doctors who interpreted the studies. Respondents assert Dr. Wagner's reliance on the interpretations of other doctors was proper since all of the doctors who treated Fragosa relied on the diagnostic testing to determine the proper course

of treatment despite the fact that they were not radiologists specifically trained to interpret the films themselves.

We disagree with Fragosa's assertion that the Appellate Panel found Dr. Wagner had "concluded" that Fragosa's diagnostic studies were unremarkable. Dr. Wagner did not find the studies unremarkable; he simply restated the findings made by the doctors who did interpret the studies. The radiologist who performed Fragosa's January 2008 CT found (1) no evidence of acute intracranial process and (2) healing skull fractures. The radiologist who conducted Fragosa's September 2008 MRI found (1) right mastoiditis and an (2) otherwise unremarkable MRI of the brain. Finally, Dr. Sandoz determined Fragosa's October 2008 EEG was within a wide range of normal limits with "no focal abnormality or seizure discharges" noted. As a neuropsychologist, Dr. Wagner is able to consider the diagnostic studies and findings of other doctors in the formation of his opinion. Thus, the Appellate Panel did not err in relying on the opinion of Dr. Wagner.

CONCLUSION

We affirm the Appellate Panel's reliance on the opinion of Dr. Wagner and remand for clarification regarding the existence of a physical brain injury.

AFFIRMED IN PART AND REMANDED.

HUFF and GEATHERS, JJ., concur.

The South Carolina Court of Appeals

Hector G. Fragosa, Employee/Claimant, Appellant,

v.

Kade Construction, LLC, Employer, and Key Risk Management Services, Inc., Carrier, Respondents.

Appellate Case No. 2012-212279

ORDER

After careful consideration of the petition for rehearing, the Court is unable to discover that any material fact or principle of law has been either overlooked or disregarded, and hence, there is no basis for granting a rehearing. Accordingly, the petition for rehearing is denied.

Thomas E. Huff J.

J. C. Gottschalk J.

James E. Lockemy J.

Columbia, South Carolina

cc:
Jeffrey Christopher Chandler, Esquire
Michael W. Burkett, Esquire
Stephen Benjamin Samuels, Esquire
John Gabriel Coggiola, Esquire

FILED
March 31, 2014

The Supreme Court of South Carolina

Hector G. Fragosa, Employee/Claimant, Petitioner,

v.

Kade Construction, LLC, Employer, and Key Risk Management Services, Inc., Carrier, Respondents.

Appellate Case No. 2014-000937
WCC File No. 0717624

ORDER

Petitioner seeks a writ of certiorari to review the Court of Appeals' decision in *Fragosa v. Kade Construction, L.L.C.*, 407 S.C. 424, 755 S.E.2d 462 (Ct. App. 2013). The petition is denied.

_____ C.J.
FOR THE COURT

Columbia, South Carolina

July 24, 2014

cc:
The Honorable Jenny Abbott Kitchings
The Honorable Virginia L. Crocker
Stephen Benjamin Samuels, Esquire
Jeffrey Christopher Chandler, Esquire
Michael W. Burkett, Esquire
John Gabriel Coggiola, Esquire

The South Carolina Court of Appeals

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August 02, 2014

The Honorable Virginia Crocker
Worker's Compensation Commission
Post Office Box 1715
Columbia SC 29202

REMITTITUR

Re: Hector G. Fragosa v. Kade Construction
Lower Court Case No. 0717624
Appellate Case No. 2012-212279

Dear Clerk of Court:

The above referenced matter is hereby remitted to the lower court or tribunal. A copy of the judgment of this Court is enclosed.

Very truly yours,

V. Claire Allen, Deputy

CLERK

Enclosure

cc: Jeffrey Christopher Chandler, Esquire
Michael W. Burkett, Esquire
Stephen Benjamin Samuels, Esquire
John Gabriel Coggiola, Esquire

DECISION AND ORDER
OF THE
APPELLATE PANEL
OF THE
SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

COMMISSION PANEL: SUSAN S. BARDEN, CHAIR; T. SCOTT BECK; H. GENE MCCASKILL

SCWCC FILE NO.: 0717624
APPELLATE CASE NO.: 2012-212279

HECTOR G. FRAGOSA,

CLAIMANT

V.

KADE CONSTRUCTION, LLC,

EMPLOYER, AND

KEY RISK INSURANCE COMPANY OF S.C.,

CARRIER, DEFENDANTS.

ON REMAND FROM THE COURT OF APPEALS OF SOUTH CAROLINA

Filed: September 30, 2014

STATEMENT OF THE CASE

This matter comes to before the Commission by way of remand from the Court of Appeals of South Carolina. *See Fragosa v. Kade Construction, LLC*, 407 S.C. 424, 755 S.E.2d 462 (Ct. App. 2013), (Cert. Denied July 24th, 2014). In accordance with the decision of the Court of Appeals, the Commission makes the following findings on remand:

FINDINGS OF FACT AND RULINGS OF LAW

1. In the Court's "CONCLUSION," the Appellate Panel is asked for "clarification regarding the existence of a physical brain injury."

2. As the Court states in its opinion under "LAW/ANALYSIS," "Respondents do not deny that Claimant suffered a physical brain injury." Therefore, the Appellate Panel has re-reviewed the record, and concludes that Claimant did not suffer physical brain damage. Based upon the evidence--and Respondents' concession--we find that Claimant suffered a physical brain injury, but not physical brain damage.

3. The Appellate Panel fully recognizes the seriousness and significance of Claimant's accident, which could have proven fatal: Claimant sustained a skull fracture, sustained hematomas, sustained a myriad other injuries, was unconscious at the scene, and had to be intubated for 16 days while hospitalized. However, the significance of the mechanics of an accident and the initial diagnoses are not dispositive in light of the standard set forth by the Supreme Court as to whether Claimant sustained permanent and serious physical brain damage (thereby entitling a claimant to receive lifetime benefits). We base this finding on the medical evidence in its entirety, including but not limited to APA, pages 417 and 430.

4. Claimant's skull fracture was not a depressed skull fracture (*i.e.*, no bone fragment actually pressed into the brain), and no surgical intervention was required for Claimant's

head injury. We base this finding on the deposition testimony of Dr. Sandoz, page 6, and on the medical evidence in its entirety.

5. As to Claimant's mastoiditis, the mastoid is not part of the brain, but part of the skull. We base this finding on the deposition testimony of Dr. Sandoz, pages 19-21, and on APA, page 699).

6. Two days after the date of the accident, Claimant was able to "answer yes/no to questions with simple words." We base this finding on APA, page 85.

7. Three days after the date of the accident, Claimant could follow simple commands. We base this finding on APA, page 107.

8. Four days after the date of the accident, Claimant opened his eyes on command, and nodded appropriately to questions. We base this finding on APA, page 124.

9. Eight days after the date of the accident, Claimant was able to follow verbal commands. We base this finding on APA, page 210; *See also* APA, page 239).

10. Nineteen days after the date of the accident, Claimant was "able to indicate that he lives in an apartment in Myrtle Beach with 5 other people." Claimant was also "able to communicate basic needs through gestures, head nods, or mouthing words," and was able to follow commands. We base this finding on APA, pages 389, and 392, and 394. *See also* pages 399, 401, 408, and 410, relating to the 20th day after the date of the accident).

11. Twenty-two days after the accident, Claimant asked for water by name (in Spanish), and was "alert" and able to follow simple commands. We base this finding on APA, pages 423 and 531.

12. Twenty-three days after the accident, Claimant was alert, followed commands, "conversive and makes sense," such that he is noted to be "mentally much improved."

Claimant inquired as to when his trach would be removed. We base this finding on APA, pages 425-426.

13. Twenty-five days after the date of the accident, Claimant was walking with his therapist in the hospital hall, conversing, oriented, and "more aware and alert." Claimant's memory is medically documented as "intact" and within normal limits. We base this finding on APA, pages 434 and 549, and accord these records great weight.

14. Twenty-seven days after the date of the accident, Claimant's memory is documented as intact and within normal limits. We base this finding on APA, pages 558, 563, and 567, and accord these records great weight.

15. Twenty-eight days after the date of the accident, Claimant's memory is documented as intact and within normal limits. We base this finding on APA, page 570, and accord this record great weight.

16. Twenty-nine days after the date of the accident, Claimant's memory is documented as intact and within normal limits. We base this finding on APA, page 575, and accord this record great weight.

17. As Claimant suffered respiratory failure on the date of the accident and ultimately had to undergo a tracheostomy and other myriad procedures, Claimant was chemically sedated with Propofol and ventilated/intubated for a good portion of his hospital stay. The following records document the fact that Claimant was comatose, chemically sedated, and unresponsive during portions of his stay (*e.g.*, APA, pages 1, 29, 39, 68, 87, 109, 126, 132, 135, 137, 152, 158, 163, 175, 184, 188, 198-199, 208, 211, 219, 274, 282, 285, 295, 308, 313, 315, 330, 332, 340, 343, 353-354, and 385).

18. Slightly less than one month after the date of the injury, Claimant expressed understanding of his foot condition and gave consent (on "2 separate occasions" via an interpreter) to the surgery that was to be performed. Other than the language barrier (for

which an interpreter was utilized), Dr. Woolf does not note any cognitive problems in his medical records. We base this finding on APA, *e.g.*, pages 413 and 440.

19. On the date of Claimant's hospital discharge, Claimant is documented as "ambulating without any difficulties" and "alert and oriented x 3." Discharge instructions were given to Claimant (not just to his family) via interpreter, and he is noted to have voiced no concerns with his hospital discharge. We base this finding on APA, pages 417-418, 444, and 578.

20. Dr. Norcross of MUSC terms Claimant's neurological recovery as "actually remarkable." Dr. Takacs (also of MUSC) states that Claimant has "no neurological sequela." We give great weight to the records of these two physicians, as they are supported by the sequential hospital records (cited *supra*). This finding is based upon APA, pages 593, 614, and 597.

21. Approximately one year after the date of the accident, Dr. Wagner found Claimant's cognitive deficits to be "relatively mild," and his Glasgow Coma Scale 15/15. The Panel finds that an assessment of "relatively mild" does not rise to the level of "most serious cases of injury to the brain," as set forth by the Supreme Court. Further, Dr. Wagner attributes some of Claimant's cognitive complaints to situational depression and pain. We find the entirety of Dr. Wagner's report compelling, as his report specifies the reasons for his conclusions. We base this finding on APA, pages 652-655.

22. Claimant's ENG shows an "incomplete right-sided vestibulopathy," and Dr. Hoy noted (in 2009) that Claimant "has improved rather significantly" after performing vestibular exercises. We base this finding on APA, page 664.

23. Although not dispositive to our decision, the Appellate Panel also notes that evidence (*i.e.*, statements and testimony from Claimant himself) shows that Claimant is able to drive (and does in fact drive), an activity which requires more than physical skill. We find this factor compelling in that Dr. Brabham bases his opinion on the fact that

Claimant "knew how to drive prior to the TBI," but now that Claimant is "unable to drive" in part because of "cognitive deficits which would result in 'errors' when driving." In fact, Claimant's only impediment to driving (as documented in physical therapy records) is restricted range of motion with regard to his neck and restricted use of his left arm. After physical therapy, Claimant was noted to be "able to turn head to drive with less difficulty..." Claimant himself admitted at the hearing that he is able to drive. The fact that Claimant denied an ability to drive to Dr. Brabham (a) results in the Panel's doubt regarding the alleged severity of Claimant's symptomatology, and (b) dilutes the strength of the Brabham opinion, as the opinion is based in part on the "fact" that Claimant is no longer able to drive (in part) because of cognitive difficulties. We base this finding on Hearing Transcript page 48, and on APA, pages 735, 744, 746, 760, 762, 812, and 869-870).

24. The Appellate Panel finds other inconsistencies in the record which call into question the alleged severity of Claimant's residual condition:

(a) Claimant contends his brain/skull injury was of a sufficient degree so as to cause hearing loss. In an intake sheet dated August 2008 (a date by which the Panel finds hearing loss would have presented itself after a November 2007 injury), Claimant responded that he had no present or past hearing loss. Further, Dr. Sandoz found Claimant's hearing "intact" at several separate medical visits. When Claimant later reported hearing loss to Dr. Sandoz (approximately a year after the date of the accident), it was on the right side. By contrast, Claimant inconsistently told Dr. Wagner that his hearing loss is "especially on the left side. Finally, Dr. Hoy (of MUSC's Otolaryngology department) found Claimant's audiogram as "entirely normal," and Claimant's examination "entirely benign." We give great weight to the findings of Dr. Hoy, and find they are consistent with Claimant's intake sheet. We base this finding on APA, pages 652, 656, 664, 666, 670-671, 674, 680, 696, 698, 700, and 702).

(b) Dr. Sandoz and Dr. Glaser found Claimant's gait "normal" or "basically normal" (Claimant had toes amputated), and his coordination intact. By contrast, Claimant told Dr. Brabham "I walk like a drunk." This factor calls into question the actual severity of Claimant's alleged symptoms. We base this finding on APA, pages 646, 692, and 715; *Cf.* APA, pages 868-869).

(c) Although Claimant testified at the hearing that his head injury has caused a "clog" in his ears, Claimant's intake sheet (10 months after the date of the accident) mentions no problem with his ears. We base this finding on Hearing Transcript, page 39, and on APA, page 670, *e.g.*).

(d) Contrary to Claimant's hearing testimony that he has difficulty swallowing, Claimant's intake sheet (completed 10 months after the date of the accident) says otherwise. We base this finding on Hearing Transcript, page 39, and on APA, page 670).

(e) Claimant did not report blurred vision on an intake sheet (completed 10 months after the date of the accident). We base this finding on APA, page 671; *See also* APA, page 430.

(f) Although Claimant testified at the hearing that he has headaches every day, Claimant reported to physical therapy personnel (beginning in December 2008) that his headaches are now "intermittent." The Panel does not dispute the fact that Claimant has headaches. We do note that Claimant reported to one provider that medication helps relieve his headaches (but we further note that Claimant did not seek medical treatment for a period of one year until the fact of the lapse was mentioned at the deposition of Dr. Sandoz). We base this finding on APA, pages 724, 740, 744, 746, 760, 762, 773, 775, 783, 801, and 803, and on the evidence as a whole.

(g) Claimant reported to Dr. Brabham that he quit smoking after his head injury because cigarettes tasted differently, leading Dr. Brabham to state that a brain injury (which

Dr. Brabham diagnosed) can often affect one's sense of taste. In fact, Claimant continued to smoke after his accident (refuting Claimant's statement upon which Dr. Brabham, in part, bases his opinion). We base this finding on the evidence in its entirety, including but not limited to APA, page 877; *Cf. e.g.*, pages 623, 630, 669 (intake sheet completed by Claimant 10 months after the date of the accident), and 673 ("half a pack per day").

(h) Dr. Merrell documents Claimant's "questionable effort" on examination. We base this finding on APA, page 630.

(i) In his treatment notes, Dr. Sandoz notes that Claimant is able to write normally, and has "good orientation to time, date, and space." We base this finding on APA, page 673).

(j) On a visual memory test, Claimant scored in the normal range. We also note that by the end of Claimant's hospital stay, his memory is noted to be intact and within normal limits. We base this finding on APA, pages 654, 707, 709, and 712-714; *Cf.* APA, pages 717; *See also* Deposition of Dr. Sandoz, pages 7 and 9-10).

(k) We find it more than coincidental that Claimant did not return to Dr. Sandoz for one year to receive any treatment. After the lapse was alluded to at Dr. Sandoz's deposition, Claimant returned 3 months later to Dr. Sandoz alleging memory loss and other ongoing problems. We believe and find that if Claimant had "serious" or "most serious" brain damage, he would have returned for treatment (for headache medication, etc.) before his failure to seek treatment was duly noted at a deposition in anticipation of litigation. We base this finding on APA, page 717, and on the deposition testimony of Dr. Sandoz, pages 6 and 15-16).

25. As to the intake sheets, we note that Claimant differentiated among "past," "present," and "never" in his responses. This factor leads the Panel to conclude that Claimant gave some

thought to his responses, and therefore we find the intake sheets reliable (APA, pages 668-671).

26. In reaching its conclusions, the Panel does not rely on the fact that Claimant's latest diagnostic tests are "unremarkable," as Claimant is not required to prove physical brain damage through an objective diagnostic medium.

27. Based upon these findings, the Appellate Panel finds that the ultimate, residual effects of Claimant's head injury are not of sufficient severity to reach the level of physical brain damage as contemplated in Section 42-9-10(C).

28. The combination of Claimant's injuries (including but not limited to his foot and his dizziness) are what totally disable him. As Claimant's brain injury is compensable pursuant to Regulation 67-1101, he is subject to the 500 week statutory limitation.

ORDER

IT IS THEREFORE ORDERED that Claimant is permanently and totally disabled and is entitled to benefits as provided in S.C. Code Ann. § 42-9-10(A) (1976, as amended). Claimant is not entitled to benefits under S.C. Code Ann. § 42-9-10(C).

AND SO IT IS ORDERED!

Susan S. Barden

T. Scott Beck

H. Gene McCaskill

South Carolina Workers' Compensation Commission

Columbia, SC

CERTIFICATE OF SERVICE

This is to certify that the undersigned has on this date served a copy of this order in the above entitled action upon all parties to this case by sending an electronic copy hereof by electronic mail addressed to the attorneys for said parties; or if there is an unrepresented party(ies), by depositing a copy hereof, postage paid in the United States mail, first class, addressed to the unrepresented party(ies) and to the attorney(s) for the represented party(ies).

By Kim Falls on September 30, 2014

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 0717624
Carrier File # 1000021953
Carrier Code #
Employer FEIN

Hector G. Fragosa
Claimant's Name SSN

Address City State Zip

Home Phone Work Phone

Kade Construction, LLC
Employer's Name

1607 James Island Ave N, N. Myrtle Beach, SC 29582
Address City State Zip

Key Risk Management Service Inc
Insurance Carrier

Michael W. Burkett (803) 227-2886
Preparer's Name Phone #

The date of injury reported on the Form 12A is: 11/1/2007

Check applicable section(s). The employer's representative requests a hearing to:

☒ I. **Stop payment of compensation.** Compensation payments are current as of 3/25/2011 (date) and shall continue until otherwise ordered or until a Form 17 is signed by the claimant. A Form 17 was offered and refused on 3/25/2011 (date)

The basis of the stop payment hearing is (check one):
☒ (a) The authorized health care provider states the claimant has reached maximum medical improvement.
☐ (b) The authorized health care provider states the claimant is able to return to the same or other suitable job and has assigned an impairment rating, if any, and the same or suitable job has been offered to the claimant.
☐ (c) The authorized health care provider states the claimant is unable to return to the same or other suitable job and has assigned an impairment rating, if any.

☐ II. **Terminate temporary compensation suspended per R.67-505.** Date suspended: _____.
The basis for suspension of benefits is (check one):
☐ (a) The claimant refuses medical treatment.
☐ (b) The employer states the claimant is working, has worked for at least fifteen calendar days, and the claimant refuses to sign the Form 17. Requesting: ☐ Informal Conference ☐ Hearing

☒ III. **Pay compensation** in the amount of $ TBD, based on the following grounds: Claimant has reached maximum medical improvement.

☒ IV. **Request Credit for overpayment of temporary compensation.**

☐ V. **Reduce Payment of compensation** from $ _____ to $ _____, based on the following grounds: _____.
Compensation payments are current as of _____ (date) and shall continue until otherwise ordered or until a Form 17 is signed by the claimant.

I certify that I have served this document pursuant to R.67-211 by delivering a copy to Jeffrey C. Chandler, Esquire, PO Drawer 1889, Myrtle Beach, SC 29578-1889; and Virginia Crocker, Judicial Director, SC WCC, P.O. Box 1715, Columbia, SC 29202-1715

On the 25th day of March 2011 by X first class postage, ____certified mail, ____personal service.

Preparer's Signature Attorney for Defendants (Title) March 25, 2011 (Date)

Michael W. Burkett
Willson Jones Carter & Baxley, P.A.
4500 Fort Jackson Boulevard
Columbia, SC 29209

The claimant may respond by writing the preparer at the address above and filing a copy of the response with the Commission's Judicial Department at the address at the top of the form. Refer to R.67-208, R.67-21 1, R.67-505, R.67-506. and R.67-601 - R.67-616. Questions about the use of this form should be directed to the Judicial Department at (803) 737-5675.

WCC FORM # 21 REV. DATE 3/97 **21** **EMPLOYER'S REQUEST FOR HEARING**

South Carolina Workers' Compensation Commission
3 Main Street, Suite 500 • Post Office Box 1715
umbia, South Carolina 29202-1715
ou3) 737-5723
www.wcc.sc.gov

WCC File #: 717624
Carrier File #: 1000021953
Carrier Code #: Unassigned
Employer FEIN #: Unassigned

Claimant's Name: Hector Gomez Fragoso SSN:
Address:
City: State: Zip:
Home Phone: Work Phone: ( ) -
Preparer's Name: Jeff Chandler Law Firm: Chandler Law Firm

Employer's Name: Kade Construction, LLC
Address: 1607 James Island Ave, N.
City: N. Myrtle Beach State: SC Zip: 29582
Insurance Carrier: Key Risk Insurance Company
Preparer's Phone #: (843) 448 - 4357

mplete each information blank. To request a hearing, check Box 13b, indicate the kinds of benefits claimed by checking the box(es) at es 6, 7, 8, and 9, and file this form in duplicate.

claim for workers' compensation benefits is made based on the following grounds: **Date of Injury or Illness: 11-01-07**

☒ Injury ☐ Illness ☐ Repetitive Trauma

1a. The claimant sustained an injury to Brain, headaches, vison, spine, both upper extremities, left shoulder, hips, both lower extremities, right foot and psychological
1b. overlay, on 11-01-2007 in Marion county, state of South Carolina.
Body part(s) affected are: Brain, headaches, vison, spine, both upper extremities, left shoulder, hips, both lower extremities, and psychological overlay.

Briefly describe how the accident occurred. Claimant sustained injury when a roof truss being carried by a crane snapped in half and fell on top of the Claimant.

2. Both the claimant and the employer were subject to the South Carolina Workers' Compensation Act at the time of injury.

3. The relationship of employer and employee existed at the time of injury.

4. At the time of the injury the claimant was performing services arising out of and in the course of employment.

5. Notice of the accidental injury was given to the Employer on 11-01-07 in the following manner: Verbally

6. Due to injury, the claimant is in need of (check one):

☐ (a) medical examination and treatment for:

☒ (b) additional medical examination and treatment for: Claimant will require lifetime medical care to control his disability.

7. Due to injury, the claimant requests temporary total disability benefits because of lost compensable time from work and wages for the period of:

From the date of injury until returning to full duty.

☒ 8. Due to the injury, the Claimant has permanent disability of the following nature and extent (check one):

☒ (1) General Disability: ☒ Total ☒ Partial ☒ (2) Specific Disability: ☒ Total ☒ Partial
☒ (3) Wage Loss

☐ 9. Due to the injury, the Claimant has a serious bodily disfigurement consisting of:

Amputation of 2nd through 5th toes on claimant's right foot and scalp scar.

10a. At the time of the injury, the Claimant was paid weekly wages of $400.00, and demands accounting of days worked and wages earned as provided by law. From the date of injury until returning to full duty.

10b. Give names and addresses of all employers for whom the Claimant has worked since the date of the accident:

11a. Further grounds or unusual aspects of claim: Any and all grounds available under the Act including proration of lump sum Award when deemed necessary under James v Anne's Inc. Additionally, this is a lifetime brain damage case.

11b. List names and addresses of all physicians or other medical specialists who have seen or treated the Claimant as a result of the accident: MUSC-- 171 Ashley Ave. Charleston, SC 29425. Strand Regional Specialty Associates – 8170 Rourk Street Myrtle Beach, SC 29572 – Atlantic Physical Therapy – 3650 Coalition Drive, Myrtle Beach, SC 29578

11c. To the best of your knowledge, did you have any prior permanent disability?
If yes, describe:

12. Appropriate benefits as provided in the Act for the above grounds and other relief as the Workers' Compensation Commission may direct as just and proper.

13a. **I am filing a claim. I am not requesting a hearing at this time.**

☒ 13b. **I am requesting a hearing. A $25 fee is required.**

14. Estimated time needed for hearing: 60-90 minutes as my clients requires the use of a translator.

rify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature | Attorney for the Plaintiff (Title) | Jeffcchandler@aol.com (Email) | 04-08-2011 (Date)

r to R.67-204 through R.67-210 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Claims Department.

: Form # 50
ed 5/07

50

Employee's Notice of Claim and/or Request for Hearing

South Carolina Workers' Compensation Commission
P.O. Box 1715 • 1612 Marion Street
Columbia, South Carolina 29202-1715
(803) 737-5700

WCC File # 0717624
Carrier File # 1000021953
Carrier Code #
Employer FEIN

Hector G. Fragosa
Claimant's Name SSN

Address City State Zip

Home Phone Work Phone

Kade Construction, LLC
Employer's Name

1607 James Island Ave N, N. Myrtle Beach, SC 29582
Address City State Zip

Key Risk Management Services, Inc.
Insurance Carrier

Michael W. Burkett (803) 227-2886
Preparer's Name Phone #

Complete each information blank. Specify clearly when contentions are admitted in part and denied in part. The employer-insurance carrier in answer to the claim, respectfully shows:

1. It is (admitted) (~~denied~~) that the employee sustained an injury on or about the date set forth in the application. The reasons for denial are: It is admitted the Claimant sustained a work injury on the date alleged; however, it is denied he sustained compensable injuries to the extent alleged in the Form 50.
2. It is (admitted) (~~denied~~) that both the employer and employee were subject to the Workers' Compensation Act at the time in question. The reasons for denial are: See number 1 above.
3. It is (admitted) (~~denied~~) that the relationship of employer and employee existed at the time in question. The reasons for denial are: See number 1 above.
4. It is (admitted) (~~denied~~) that at the time in question the employee was performing services arising out of and in the course of employment. The reasons for denial are: See number 1 above.
5. It is (admitted) (~~denied~~) that notice of injury was given the employer. The reasons for denial are: See number 1 above.
6. It is (admitted) (~~denied~~) that the employee needs or is entitled to additional medical care as a result of injury. The reasons for denial are: See number 1 above. Claimant has reached maximum medical improvement and no further medical care will tend to lessen any period of disability.
7. It is (~~admitted~~) (denied) that the employee is entitled to temporary total disability for the period(s) of: See numbers 1 and 6 above.
8. It is (~~admitted~~) (denied) that the employee is permanently disabled. The reasons for denial are: See numbers 1, 6, and 7 above.
9. It is (~~admitted~~) (denied) that the employee has a serious disfigurement. See numbers 1, 6, 7 and 8 above.
10. It is contended that an average weekly wage of $ 400.00 applies, according to attached accounting of employee's earnings as provided by law.
11. Further contentions or grounds of defense are: Defendants reserve the right to amend and to assert defenses as they become aware of them.

I certify that I have served this document pursuant to R.67-212 by delivering a copy to Jeffrey C. Chandler, Esquire,
Name

PO Drawer 1889, Myrtle Beach, SC 29578-1889 and Virginia Crocker, Judicial Director, SC WCC, P.O. Box 1715, Columbia, SC 29202
Address

on the 19th day of April, 2011 by ☒ first class mail; ☐ personal service; ☐ certified mail.

I verify the contents of this form are accurate and true to the best of my knowledge.

Preparer's Signature, Attorney for Defendants
Michael W. Burkett
Willson Jones Carter & Baxley, P.A.
4500 Fort Jackson Boulevard
Columbia, SC 29209

Kellie J. Bobo, Certifier

April 19, 2011
Date

Refer to R.67-205 and R.67-601 through R.67-615. Questions about the use of this form may be directed to the Commission's Judicial Department. Pursuant to R.67-606, a Form 20 must be filed with the Claims Department at least 30 days from the date of filing this form.

South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500
P.O. BOX 1715
Columbia, SC 29202-1715
(803) 737-5739
www.wcc.sc.gov

PRE-HEARING BRIEF
WCC File No: 0717624

Claimant's Name: Hector Fragoso
Address:
City: State: Zip:
Home Phone: Work Phone: ( ) -
Preparer's Name: Jeff Chandler

Employer's Name: Kade Construction, LLC
Address: 1607 James Island Ave N
City: N. Myrtle Beach State: SC Zip: 29582
Carrier: Key Risk Management Services, Inc.
Preparer's Phone #: (803) 227-2886

A claim for workers' compensation benefits is made based on the following grounds:
☒ Injury ☐ Illness ☐ Repetitive Trauma

1. Compensation Rate: $266.68 2. AWW: $400.00 **Date of Injury:** 11/01/07
3. Type of injury and body part(s): Brain, headaches, vision, spine, both upper extremities, left shoulder, hips, both lower extremities, right foot and psychological overlay.
4. Facts in controversy: 1.) Claimant contends that he is entitled to lifetime benefits under 42-9-10 as a result of the physical brain damage that has rendered him totally and permanently disabled.
5. Legal issues involved: 42-9-10; 42-9-20; 42-9-30; 42-15-60; 42-9-301; 67-1101
6. Unusual aspects: Claimant will require a translator for testimony.
7. Witnesses (designate if expert):* Claimant
8. Exhibits: Deposition Transcript of Dr. George Sandoz-- Psychological and Vocational evaluation-- Medical Questionnaire from Dr. George Sandoz
9. Medical evidence (indicate report pursuant to R.67-612; deposition or appearance): See attached Notice of APA Submissions.
10. Name, address, and specialty, if any, of the treating physician: Dr. George Sandoz – 8171 Rourk Street Myrtle Beach, SC 29572 Neurologist.
11. Impairment rating(s); body part(s); physician and date of opinion: Claimant was assigned a 1% impairment rating to his left shoulder by Dr. Shane Wolfe on 02-24-2010 , 40% to the right lower extremity by Dr. Shane Wolfe on 04-08-2010, 11% to the cervical spine by Dr. Christopher Merrill on 02-28-10, and was assigned a 46% whole person rating by Dr. George Sandoz on 08-20-2009.
12. I am amending my Form 50/51 in the following manner: Hearing loss for Right Ear due to Mastoiditis.

I verify the contents of this form are accurate and true to the best of my knowledge.

Signature:
Email: Jeffcchandler@aol.com
Date of hearing: 05/11/11
Time needed for hearing: 1 Hour
On behalf of ☒ Claimant ☐ Employer

File this form and proof of service on the opposing party according to R.67-611 and R.67-212. Do not send medical reports.
* Commissioners reserve the right to admit expert witnesses at hearings.

MUSC Medical Center
CONSULTATION REPORT
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date: 11/01/2007
Service: Orthopedic
Attending: Shane K. Woolf, MD

HISTORY OF PRESENT ILLNESS: The patient is a 56-year-old patient, at a construction site was hit in the head with a crane. Apparently he vomited prior to the ED arrival, with unsuccessful intubation at an outside hospital. Past medical history none. No known drug allergies. No known previous surgeries, no current medical conditions. Apparently could smell alcohol on the patient's breath. Questionable tobacco use.

FAMILY HISTORY: Noncontributory.

REVIEW OF SYSTEMS: Unable to obtain.

This patient incurred a large fracture through his skull, apparently it is open, with subdural and epidural fluid collections. Orthopedics was consulted for a right clavicle fracture as well as fractures of the proximal phalanges of the right foot, 2-12, with traumatic arthrotomies of the 4th and 5th toes as well as a nondisplaced oblique fracture of the right great toe.

PHYSICAL EXAMINATION: The patient is a Hispanic male, intubated, sedated. Apparently he was moving all extremities upon admission. His right upper extremity is noted to have some bruising and swelling about the right hand, but no crepitus is noted about the hand, wrist, elbow, arm, or shoulder. There is gross crepitus at the right clavicle. The left upper extremity is unremarkable. Again it was moving, apparently, on admission. There is no crepitus or step-off noted. His left lower extremity also has no obvious injuries, swelling, step-offs, crepitus noted about the hip, thigh, knee, leg, or ankle or foot. The right foot is significant for traumatic arthrotomies of the 4th and 5th digits, and gross swelling about the foot. The ankle appears to be intact without any swelling or bony step-offs or crepitus, as well as the leg, knee, and thigh, and there is range of motion in his hip without crepitus. His pelvis is stable to AP and lateral compression. Abdomen is soft, nontender, nondistended.

ASSESSMENT: Hispanic male with the aforementioned injuries with traumatic arthrotomies at the 4th and 5th toes of the right foot as well as right clavicle fracture. Will apply a splint to the clavicle fracture. The arthrotomies will be washed out and assessed. Antibiotics q. 8h will be recommended, and patient apparently is not a surgical candidate at the moment per neurosurgery. Will possibly take him to the OR for more definitive washout and closure and possible pinning of the fractures at a future date.

The plan has been discussed with the attending and he is in agreement.

Dictated by: Bennett Grimm, MD

Bennett Grimm, MD

Shane K. Woolf, MD
Attending

902536 / 35634 /
JOB: 367701
DD: 11/01/07 08:40 PM
DT: 11/02/07 12:19 PM

Additional CC:

DOCID: 18231902536

Electronically signed by SHANE WOOLF, on 11-19-2007 at 10:22:19 AM

MUSC Medical Center
CONSULTATION REPORT
Patient Name: TRAUMA, VICTIM JW
MRN: 002581962
Patcom: 490943644
Date: 11/01/2007
Service: Neurosurgery Service
Attending: Istvan Takacs, MD

CHIEF COMPLAINT AT TIME OF ADMISSION: Status post fall.

HISTORY OF PRESENT ILLNESS: A 27-year-old Hispanic male who was working at a construction site as per report, the counterweight of the crane fell on his head. He has a left scalp laceration, intubated. As per report, he was combative at the scene and had some vomiting. His wound was cleaned and sutured by the trauma service. Among other injuries, he has right big toe fracture, right fifth toe fracture, right clavicle fracture.

ALLERGIES: None.

MEDICATIONS: None.

PAST MEDICAL HISTORY: Unknown.

PAST SURGICAL HISTORY: Unknown.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: Unknown.

REVIEW OF SYSTEMS: Unable to obtain.

PHYSICAL EXAMINATION: Pulse 101, respiratory rate 18, blood pressure 117/82, sats 100% on vent. Neck: He is in C-collar. Head and face: He has some left frontoparietal laceration. Heart: Regular rate and rhythm. Lungs: Bilaterally clear. Abdomen: Soft, nontender. Neuro examination on minimal sedation is E2, V1, M5, GCS of 8/10. Cranial nerves: He has bilateral pupils 2 mm and nonreactive. His face appears to be symmetric. He localizes bilateral upper and lower extremities briskly. His toes are downgoing bilaterally. CT of the head reveals a left scalp laceration with scalp hematoma with left frontoparietal skull fracture which extends to the base of the skull with minimal underlying contusion. CT scan of the C-spine reveals a C7-T1 transverse process fracture. No fractures or malalignment otherwise. T and L films reveal no fractures.

LABORATORIES: Sodium is 143, potassium 3.9, BUN 13, creatinine 1.2, white count 15.1, H&H of 10.3 and 30.7, platelets of 207, PT of 17.7, INR of 1.4.

ASSESSMENT AND PLAN: Patient is a 27-year-old status post closed head injury with open skull fracture. We recommended ICU admission, frequent neuro checks. start vancomycin and Claforan. Keep INR less than 1.3, platelets greater than 100,000, sodium between 135 and 140, normal temperature. We will recommend starting on antiepileptics for seizure prophylaxis. We will discuss the patient's details with Dr. Takacs. There is no need for repeat imaging at this point unless the exam declines. We will continue to follow.

Dictated by: Vibhor Krishna, MD

_____
Vibhor Krishna, MD

_____
Istvan Takacs, MD
Attending

901511 / 41177 /
JOB: 367697
DD: 11/01/07 07:25 PM
DT: 11/02/07 11:57 AM

Additional CC:_____

DOCID: 18231901511

Edited By VIBHOR KRISHNA on 11-19-2007 at 08:46:28 PM
Electronically signed by ISTVAN TAKACS, MD on 12-05-2007 at 08:44:50 PM

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5075390

MRN: 002581962
Date Exam Completed: 11/01/2007 18:15
Last Update: 11/02/2007

EXAMINATION: CT BRAIN 11/01/07 18:15:00

ACCESSION NUMBER: 5075390

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: None

TECHNIQUE: Multiple contiguous five mm axial CT images were obtained through the brain without IV contrast.

FINDINGS: There is a minimally displaced fracture with significant diastases extending longitudinally from left occipital bone up to the parietal, temporal and frontal bone and extending obliquely through the left orbital roof. There is associated midline small parietal extra-axial hemorrhage.there is small amount of pneumocephalus along the fracture line, worrisome for a small epidural hematoma. There are also bilateral basilar frontal contusions. Ventricles are small but symmetric in size. There is no evidence of herniation. There is diastases of right coronal suture and dorsal part of the sagittal suture. There is opacification of the nasal passages and fluid layering in the sphenoid and left maxillary sinus, likely traumatic. If nondisplaced skull base or facial fractures are suspected thin cut facial CT may be considered Mastoid air cells are well aerated. There is significant scalp hematoma and emphysema. Endotracheal and oro gastric tubes are in place.

IMPRESSION:

1. Comminuted fracture as above with small extra-axial parietal hematoma at midline at the vertex, worrisome for a small epidural hematoma.

Findings were discussed with Dr. Hiott and Dr. Wilson

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:45 AM
Printed by: LINCOLN, COURTNEY

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT ABDOMEN W/CONTRAST
Accession #: 5075388

MRN: 002581962
Date Exam Completed: 11/01/2007 18:18
Last Update: 11/02/2007

EXAMINATION: CT ABDOMEN 11/01/07 18:18:00

ACCESSION NUMBER: 5075388

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: None

TECHNIQUE: Multiple 2 mm axial CT images were obtained of the abdomen from the domes of the diaphragm to the iliac crest after the intravenous bolus administration of 140 cc Omnipaque 300 (iohexol) without immediate adverse reaction. Sagittal and coronal reformatted images were generated. Please refer to separate CT of the chest and pelvis for pertinent findings in those regions.

FINDINGS: The liver, spleen, gallbladder, pancreas, left adrenal gland and kidneys show no evidence for acute injury. There is a right adrenal hemorrhage. The gastrointestinal tract is also unremarkable without wall thickening or obstruction. Abdominal and hepatic vasculature is normal. There is no evidence for free intraperitoneal gas, fluid or lymphadenopathy. Review of bony structures demonstrates bilateral L1-2 transverse process fractures, and right L3 transverse process fracture.

IMPRESSION:

1. Right adrenal hemorrhage.

2. Bilateral L1-2 and a right L3 transverse process fractures and multiple posterior right rib fractures.

Findings were discussed with Dr. Wilson by Dr. Fernandez at completion of the exam.

Please refer to separate CT of the chest and pelvis for additional pertinent findings in those regions.

VOICE DICTATED BY: Dr. MIGUEL FERNANDEZ
I have reviewed the images and agree with the findings in this report.

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

History: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

Technologist: JOYCE WILKINSON
Interpreter 1: TIMOTHY ALDER
Interpreter 2: MIGUEL FERNANDEZ
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: TIMOTHY ALDER
Date Authenticated: 11/2/2007

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Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT CHEST W/ CONTRAST
Accession #: 5075391

MRN: 002581962
Date Exam Completed: 11/01/2007 18:20
Last Update: 11/02/2007

EXAMINATION: CT CHEST 11/01/07 18:20:00

ACCESSION NUMBER: 5075391

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: chest radiograph same day

TECHNIQUE: Multiple 2 mm axial CT images were obtained of the thorax from the level the clavicles to the domes of the diaphragm after the bolus administration of 140 cc Omnipaque 300 (iohexol) without immediate adverse reaction. Sagittal and coronal reformatted images were generated. Please refer to separate CT of the abdomen and pelvis for additional pertinent findings below the level of the diaphragm.

FINDINGS: The aorta and great vessels are unremarkable in course and caliber without evidence for acute injury. There is no evidence for mediastinal hematoma or pericardial effusion. Evaluation of lung parenchyma demonstrates bilateral patchy consolidation compatible with lung contusions and/or aspiration. There is no pneumothorax or pleural effusion. The endotracheal tube is low in position just proximal to the carina. Review of bony structures demonstrates a right clavicle fracture as well as C7 and T1 spinous process fractures. In addition, right T8 through 10 and T11 rib fractures are noted.

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IMPRESSION:

1. Bilateral lung contusions and/or aspiration.

2. Right clavicle fracture and C7 and T1 spinous process fractures.

3. Low position of the endotracheal tube, recommend withdrawing approximately 1.0 cm.

Findings were discussed with Dr.Wilson by Dr.Fernandez at the completion of the exam.

Please refer to separate CT of the abdomen and pelvis for additional pertinent findings.

VOICE DICTATED BY: Dr. MIGUEL FERNANDEZ

History: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

Technologist: JOYCE WILKINSON
Interpreter 1: TIMOTHY ALDER
Interpreter 2: MIGUEL FERNANDEZ
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist:
Date Authenticated:

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5075386

MRN: 002581962
Date Exam Completed: 11/01/2007 17:18
Last Update: 11/02/2007

EXAMINATION: CHEST 11/01/07 17:18:00

ACCESSION NUMBER: 5075386

INDICATION: EHIT IN HEAD, ETT

COMPARISON: None.

FINDINGS: Single frontal radiograph of the chest demonstrates normal size and contour of the cardiomedistinal silhouette. There is right apical and left peritracheal airspace opacity, representing contusion versus atelectasis. There is no evidence of pneumothorax. Endotracheal tube overlies tracheal air column and terminates at the level of carina. Enteric catheter transverses the thorax and terminates overlying proximal stomach. There is midshaft right clavicular fracture with significant diastases and superior displacement of distal fracture fragment.

IMPRESSION:

1. Bilateral apical contusions versus atelectasis

2. Right midshaft clavicular fracture

Findings were discussed with Dr. Wilson

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

History: EHIT IN HEAD, ETT

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5075386

MRN: 002581962
Date Exam Completed: 11/01/2007 17:18
Last Update: 11/02/2007

Technologist: CASSANDRA FERRELL
Interpreter 1: TIMOTHY ALDER
Interpreter 2: DOBRINKA DIMITROVA
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: TIMOTHY ALDER
Date Authenticated: 11/2/2007

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG FOOT AP/LAT VIEWS
Accession #: 5075393

MRN: 002581962
Date Exam Completed: 11/01/2007 18:20
Last Update: 11/02/2007

EXAMINATION: Right FOOT XRAY 11/01/07 18:20:00

ACCESSION NUMBER: 5075393

INDICATION: 58 YO MALE S/P CRUSH INJURY

COMPARISON: None

FINDINGS: AP, lateral, and oblique views of the foot labelled right reveals displaced oblique fractures through first, third, fourth and fifth right distal phalanx, second, third, fourth and fifth proximal phalanges, and fracture through the fifth middle phalanx.

IMPRESSION:

1.Fractures of all five sets of phalanges as described above.

Findings were discussed with Dr. Wilson

VOICE DICTATED BY: Dr. Dobrinka Dimitrova I have reviewed the images and agree with the findings in this report.

History: 58 YO MALE S/P CRUSH INJURY

Technologist: JANET WILSON
Interpreter 1: WILLIAM CONWAY

Proxy Signer:

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Printed: 01/07/2008 10:45 AM
Printed by: LINCOLN, COURTNEY

Interpreter 2: DOBRINKA DIMITROVA
Interpreter 3: MADELINE LEWIS
Date Dictated:

Authenticating Radiologist: WILLIAM CONWAY
Date Authenticated: 11/2/2007

Transcribed by: Tech IntTalk

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Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR **MRN: 002581962**
Procedure: CT PELVIS W/CONTRAST Date Exam Completed: 11/01/2007 18:19
Accession #: 5075389 Last Update: 11/02/2007

EXAMINATION: CT PELVIS 11/01/07 18:19:00

ACCESSION NUMBER: 5075389

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: None

TECHNIQUE: Mutiple 2 mm axial CT images were obtained of the pelvis from the iliac crest to the symphysis pubis after the uneventful intravenous administration of 140cc of Omnipaque 300 (iohexol). Sagittal and coronal reformatted images were generated. Please refer to separate CT of the chest and abdomen for additional pertinent findings above the iliac crests.

FINDINGS: Limited evaluation of the lower gastrointestinal tract demonstrates a high density tubular structure in the rectum. The urinary bladder contains a foley balloon catheter. There is no free intraperitoneal gas or fluid. There is no lymphadenopathy. There is no evidence for acute osseous injury.

IMPRESSION:

1. No evidence of acute pelvic trauma with a high density structure in the rectum of uncertain significance.

Findings were discussed with Dr.Wilson by Dr.Fernandez at the completion of the exam.

Please refer to separate CT of the chest and abdomen for additional pertinent findings above the iliac crests.

VOICE DICTATED BY: Dr. MIGUEL FERNANDEZ
I have reviewed the images and agree with the findings in this report.

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR **MRN:** 002581962

Procedure: CT PELVIS W/CONTRAST Date Exam Completed: 11/01/2007 18:19

Accession #: 5075389 Last Update: 11/02/2007

History: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

Technologist: JOYCE WILKINSON

Interpreter 1: TIMOTHY ALDER

Interpreter 2: MIGUEL FERNANDEZ

Interpreter 3:

Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: TIMOTHY ALDER

Date Authenticated: 11/2/2007

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Patient: **GOMEZ-FRAGOSO, HECTOR** **MRN: 002581962**
Procedure: CT HEAD/BRAIN W/O CONTRAST Date Exam Completed: 11/01/2007 18:15
Accession #: 5075390 Last Update: 11/02/2007

EXAMINATION: CT BRAIN 11/01/07 18:15:00

ACCESSION NUMBER: 5075390

INDICATION: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

COMPARISON: None

TECHNIQUE: Multiple contiguous five mm axial CT images were obtained through the brain without IV contrast.

FINDINGS: There is a minimally displaced fracture with significant diastases extending longitudinally from left occipital bone up to the parietal, temporal and frontal bone and extending obliquely through the left orbital roof. There is associated midline small parietal extra-axial hemorrhage.there is small amount of pneumocephalus along the fracture line, worrisome for a small epidural hematoma. There are also bilateral basilar frontal contusions. Ventricles are small but symmetric in size. There is no evidence of herniation. There is diastases of right coronal suture and dorsal part of the sagittal suture. There is opacification of the nasal passages and fluid layering in the sphenoid and left maxillary sinus, likely traumatic. If nondisplaced skull base or facial fractures are suspected thin cut facial CT may be considered Mastoid air cells are well aerated. There is significant scalp hematoma and emphysema. Endotracheal and oro gastric tubes are in place.

IMPRESSION:

1. Comminuted fracture as above with small extra-axial parietal hematoma at midline at the vertex, worrisome for a small epidural hematoma.

Findings were discussed with Dr. Hiott and Dr. Wilson

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

Patient: GOMEZ-FRAGOSO, HECTOR **MRN:** 002581962
Procedure: CT HEAD/BRAIN W/O CONTRAST Date Exam Completed: 11/01/2007 18:15
Accession #: 5075390 Last Update: 11/02/2007

History: 58Y/O MALE S/P TRAUMA OF CRANE HITTING HIS HEAD 6" LACERATION

Technologist: JOYCE WILKINSON
Interpreter 1: MARIA SPAMPINATO
Interpreter 2: DOBRINKA DIMITROVA
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: MARIA SPAMPINATO
Date Authenticated: 11/2/2007

Transcribed by: Tech IntTalk

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Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR **MRN:** 002581962
Procedure: DIAG HAND,MINIMUM 3 VIEWS Date Exam Completed: 11/01/2007 20:40
Accession #: 5075466 Last Update: 11/02/2007

EXAMINATION: HAND 11/01/07 20:40:00

ACCESSION NUMBER: 5075466

INDICATION: MVC, swelling R hand, wrist

COMPARISON: None.

FINDINGS: Frontal, lateral, and oblique views of right hand demonstrate the bones to be well mineralized. There is no evidence of acute bony, joint, or soft tissue abnormality. There is no evidence of acute fracture or dislocation. The joint spaces are well-maintained. Carpal alignment is intact.

IMPRESSION:

1. Normal right hand.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

History: 20? yo HM s/p MVC

Technologist: DEBRA CAPPS
Interpreter 1: WILLIAM CONWAY
Interpreter 2: MADELINE LEWIS

Proxy Signer:

Authenticating Radiologist: WILLIAM CONWAY

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Interpreter 3:

Date Authenticated: 11/2/2007

Date Dictated:

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Patient: **GOMEZ-FRAGOSO, HECTOR** **MRN: 002581962**
Procedure: DIAG FOREARM, AP/LAT
Accession #: 5075468
Date Exam Completed: 11/01/2007 20:41
Last Update: 11/02/2007

EXAMINATION: FOREARM 11/01/07 20:41:00

ACCESSION NUMBER: 5075468

INDICATION: MVC, swelling R hand, wrist

COMPARISON: None.

FINDINGS: Frontal and lateral views of right forearm demonstrate the bones to be well mineralized. There is no evidence of acute bony, joint, or soft tissue abnormality. There is no evidence of acute fracture or dislocation. The joint spaces are well-maintained.

IMPRESSION:

1. Normal right forearm.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

History: 20? yo HM s/p MVC

Technologist: DEBRA CAPPS
Interpreter 1: WILLIAM CONWAY
Interpreter 2: MADELINE LEWIS
Interpreter 3:

Proxy Signer:

Authenticating Radiologist: WILLIAM CONWAY
Date Authenticated: 11/2/2007

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Printed: 01/07/2008 10:44 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG FOREARM, AP/LAT
Accession #: 5075468

MRN: 002581962
Date Exam Completed: 11/01/2007 20:41
Last Update: 11/02/2007

Date Dictated:

Transcribed by: Tech IntTalk

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Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG ELBOW AP/LAT
Accession #: 5075473

MRN: 002581962
Date Exam Completed: 11/01/2007 20:42
Last Update: 11/02/2007

EXAMINATION: ELBOW, 11/01/07 20:42:00

ACCESSION NUMBER: 5075473

INDICATION: MVC, swelling right hand and wrist

COMPARISON: None.

FINDINGS: Frontal and lateral views of right elbow demonstrate the bones to be well mineralized. There is no evidence of acute bony, joint, or soft tissue abnormality. There is no evidence of acute fracture or dislocation. The joint spaces are well-maintained. There is no evidence of effusion. There are punctate densities overlying the anterior lateral forearm likely artifact.

IMPRESSION:

1. Normal right elbow.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

History: 20? yo HM s/p MVC

Technologist: DEBRA CAPPS
Interpreter 1: WILLIAM CONWAY

Proxy Signer:

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Printed: 01/07/2008 10:44 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG ELBOW AP/LAT
Accession #: 5075473

MRN: 002581962
Date Exam Completed: 11/01/2007 20:42
Last Update: 11/02/2007

Interpreter 2: MADELINE LEWIS
Interpreter 3:
Date Dictated:

Authenticating Radiologist: WILLIAM CONWAY
Date Authenticated: 11/2/2007

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Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5075505

MRN: 002581962
Date Exam Completed: 11/01/2007 22:53
Last Update: 11/02/2007

EXAMINATION: CHEST 11/01/07 22:53:00

ACCESSION NUMBER: 5075505

INDICATION: 28 yo hit by a crane with LOC and foot fractures and rib fractures

COMPARISON: 11/01/07.

FINDINGS: Single frontal radiograph of the chest demonstrates normal size and contour of the cardiomedistinal silhouette. There has been interval withdrawal of endotracheal tube, with its distal tip now 2 cm from the carina. Enteric catheter is unchanged. Again noted are bilateral apical air space opacities, contusions versus atelectasis or aspiration. There is no evidence of pneumothorax. Right clavicular fracture is also noted.

IMPRESSION:

1. Status-post repositioning of endotracheal tube

2. Bilateral apical opacities, contusions versus atelectasis or aspiration

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

History: 28 yo hit by a crane with LOC and foot fractures and rib fractures

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5075505

MRN: 002581962
Date Exam Completed: 11/01/2007 22:53
Last Update: 11/02/2007

Technologist: LAKEISHA WILLIAMS
Interpreter 1: PHILIP COSTELLO
Interpreter 2: DOBRINKA DIMITROVA
Interpreter 3: MARQUES BRADSHAW
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: PHILIP COSTELLO
Date Authenticated: 11/2/2007

HISPHYS

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Adult Initial Neurosurgery Evaluation

Form Origination Date: new
Version: Version Date: in progress

Date: 11/1/07
☐ Neurosurgery H&P ☒ Neurosurgery Consult

P490943644
TRAUMA
VICTIM JW
Adm: 11/01/07 M2581962
Patient Na...
MRN 2581962
STAMP PLATE AREA

Requesting MD/Service: _____ Location of consult: ☒ ER ☐ ( ) ICU ☐ Floor ( ) ☐ Other: _____

Chief Complaint: _____

HPI (4): 27 y/o ♂ @ work had a counter weight of crane fall on his feet → (L) scalp lac. intubated @ MUSC, vomited, after washout. Has combative, ↓ vomiting @ scene. smells of ETOH.

(R) big toe fx, (R) [illegible] fx, (R) clavicle fx

(Location, duration, timing, severity, quality, context, things that relieve or exacerbate, associated symptoms)

Medical Allergies: unknown
Medications: ϕ

ROS (NAT = Not able to test)

Neuro	☐ Neg	☐ NAT		Endocrine	☐ Neg	☐ NAT	
General	☐ Neg	☐ NAT		GI	☐ Neg	☐ NAT	
Hematologic	☐ Neg	☐ NAT		GU	☐ Neg	☐ NAT	
ENT	☐ Neg	☐ NAT		Musculoskeletal	☐ Neg	☐ NAT	
Cardio/Vasc	☐ Neg	☐ NAT		Skin	☐ Neg	☐ NAT	
Respiratory	☐ Neg	☐ NAT		Psych	☐ Neg	☐ NAT	
Eyes	☐ Neg	☐ NAT		Other	☐ Neg	☐ NAT	

PMH ϕ

PSH ϕ

Family Hx NC.

Social Hx unknown.

PE: Temp ____ Tmax ____ Pulse 101 B/P 117/82 Resp 18 ☐ Ventilated: 100% on vent

General Appearance: _____

Nutrition: ☐ NPO ☐ Tube Feeds ☐ PN ☐ Fluids ☐ Solids Activity: ☐ Bedrest ☐ In chair ☐ Ambulating

General Exam (NE = Not examined)

Neck	☐ WNL	☐ NE	w C-collar	Right arm	☐ WNL	☐ NE	
Head / face	☐ WNL	☐ NE	bruising (L) fx-par-	Left arm	☐ WNL	☐ NE	
Heart	☐ WNL	☐ NE	RRR	Right leg	☐ WNL	☐ NE	
Lungs	☐ WNL	☐ NE	b/l air entry	Left leg	☐ WNL	☐ NE	
Abdomen	☐ WNL	☐ NE	soft, ND	Other			
GU	☐ WNL	☐ NE					
Rectal	☐ WNL	☐ NE					

Resident/MLP Signature _____ Pager ID 15388 Date 11/1/07 Time 18:43 AM/PM

Attending Signature _____ Pager ID _____ Date _____ Time _____ AM/PM

neurosadultinitaleval

OTE 900396 7/06

HISPHYS

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Adult Initial Neurosurgery Evaluation

Form Origination Date: 7/06
Version: 1 Version Date: 7/06

Date: 11/1/07

P490943644 DOB:01/01/1851 U U
TRAUMA
VICTIM JW
Adm:11/01/07 M2581962
Patient Nam
MRN 2581962
STAMP PLATE AREA

Neuro Exam ☐ Minimal or no medical sedation ☐ Heavily sedated ☐ Sedated and pharmacologically paralyzed

Neuro:	Best motor exam:	☐ Spontaneously	☐ To command (5)	☒ Localizes (5)	☐ Withdrawals (4)	☐ ABN flexion (3)	☐ ABN extension (2)	☐ None (1)
	Best verbal exam:	☐ Normal	☐ Oriented (5)	☐ Confused (4)	☐ Inappropriate (3)	☐ Incomprehensible (2)	☒ None (1)
GCS	Best eye opening:	☐ Spontaneous (4)	☐ To speech (3)	☒ To pain (2)	☐ None (1)		
	Alertness:	☐ Alert	☐ Drowsy but arousable	☐ Lethargic, difficult to arouse	☐ Confused / delirious	☐ Unresponsive	
9/10	Orientation:	☐ NAT (Not able to test)	☐ Oriented to time, place, person	☐ Oriented only to: ☐ Time ☐ Place ☐ Person	☐ None Other:		
	Memory:	☐ NAT	☐ Appears WNL	☐ 3/3 objects at 5 min Other:			
	Knowledge:	☐ NAT	☐ Appears WNL	☐ 3/3 objects at 5 min Other:			

CN 2	V fields / acuity	☐ NAT	☐ Normal fields ☐ Normal acuity gross ☐	CN 7	Facial movements	☐ NAT	☒ Normal facial symmetry ☐
Discs	☐ Not seen well	☐ NAT	☐ No papilledema ☐	CN 8	Hearing	☐ NAT	☐ Normal hearing bilaterally
CN 3, 4, 6	Pupils	☐ NAT	☐ PERRL ☒ Right pupil 2 mm ☐ RRL ☐ Other: ☒ Left pupil 2 mm ☐ RRL ☐ Other:	CN 9, 10	Soft palate	☐ NAT	☐ Rises symmetrically
	EOM	☐ NAT	☐ EOM full ☐	CN 11	Sternocleidomastoid & Trapezius	☐ NAT	☐ NL Sternocleidomastoid & Trapezius
CN 5	Facial sensations	☐ NAT	☐ Facial sensation normal ☐ ☐ Rt corneal ☐ Present ☐ Absent ☐ Lt corneal ☐ Present ☐ Absent	CN 12	Tongue	☐ NAT	☐ Midline, normal

Strength	☐ NAT	☐ All Normal	Right ARM ☐ Normal ☐		Left ARM ☐ Normal ☐								
			Right LEG ☐ Normal ☐		Left LEG ☐ Normal ☐								
			Hemiparesis: ☐ Right:		☐ Left:								
Motor Group Specific	☐ NAT		Del	Bic	Tri	WE	Grip	HI	Other:	IP	Quad	Ham	DF	EHL	PF	Other:
		Right	+													
		Left	+													
Sensation	☐ NAT	☐ All Normal	Right ARM ☐ Normal ☐		Left ARM ☐ Normal ☐											
			Right LEG ☐ Normal ☐		Left LEG ☐ Normal ☐											
			Sensory level:		Other:											

Gait	☐ NAT	☐ Normal ☐
Babinski	☐ NAT	Right ☒ Absent ☐ Present Left ☒ Absent ☐ Present
Coor	☐ NAT	☐ Normal Rt FN ☐ ABN ☐ Normal Rt FN ☐ ABN
Tone	☐ NAT	☐ WNL ☐
Pulses	☐ NAT	☐ Carotid WNL ☐

Radiology:
CT head - ① scalp
① Fr/parietal skull fx
② underlying min contusion
C-spine C6/7, SP fx - posterior
TAL exam - 6 hr

ABG: / /
O2:
Vent:

14.3	13		
3.9	1.2	15	30
PT/PTT=	13.7		
INR=	1.4		
Dilantin=			

Abbreviations: EVD=External ventricular drain; NAT=Not able to test; Del=Deltoids; Bic=Biceps; WE=Wrist extensors; HI=Hand intrinsics; IP=Iliopsoas; Quad=Quadriceps; Ham=Hamstring; EHL=Extensor hallucis longus; PF=Plantar flexors; DF=Dorsi flexors

A/P: 27yo M s/p GHI c open skull fx -
1. Admit c IVF, admission, frequent neurochecks
2. Agree c Vanc/Zosyn/Dilantin
3. Keep I/O [illegible] Na+ = 135-140, Normal temp, Hct [illegible]
4. Will dw Dr. Takacs.
5. No need to repeat imaging unless exam declines

Resident/MLP Signature _____ Pager ID 15388 Date 11/1/07 Time 18:43 AM/PM

☐ I, _____ saw and evaluated the patient. Discussed with residents and/or MLP and agree with their findings and plan as documented in the note.
☐ More than 50% of this visit (_____ min total) was spent on education and counseling.

Attending Signature _____ Pager ID _____ Date _____ Time _____ AM/PM
neurosacutlinitaleval OTE 900395 7/06

* H I S P H Y S *

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P490943644 DOB:01/01/1851 U U
TRAUMA
VICTIM JW
Adm:00000000 M2581962

Trauma Center Initial Patient Evaluation
Page 1 of 6

HISTORY

Chief Complaint (Mechanism of Injury): ☐ Auto-ped ☐ MVC ☐ Motorcycle Crash ☐ Gunshot ☐ Shotgun ☑ Fall - object fell on pt ☐ Stabbing ☐ Assault ☐ Other (describe): _____

History of Present Illness: ☐ Check if complete HPI cannot be obtained due to need for urgent evaluation and/or urgent management of patient's condition

Source(s) of History: ☐ Patient ☑ EMS ☐ Family ☐ Police ☐ Other: _____

Patient Age: _____ Patient Gender: ☐ M ☐ F

Patient Origin: ☐ Scene ☐ Walk-in ☐ Transfer: Referring hospital: _____ ☑ Other: Marion County

Transport Mode to MUSC: ☐ Ground Ambulance ☑ Helicopter ☐ Private Vehicle ☐ Other: _____

Time from event to MUSC arrival: _____

History of event (to include any history of LOC):
56 yo pt at a construction site c a crane elevated & it fell & hit him.

Prehospital Course:
-Vomiting x1 prior to EMV arrival
-Tried to be intubated by Marion County unsuccessful, when Carolina Life care arrived they were able to intubate
Pt got 1 Lidocaine prior to arrival

Subjective Complaints (location and severity of symptoms):
unable to speak

Modifying Factors (EtOH consumption, environmental hazards, etc):
unknown

Safety Devices in use (check all that apply): ☐ Not applicable ☑ Unknown ☐ Seat belt ☐ Shoulder Restraint ☐ Helmet ☐ Other (Describe): _____

Additional HPI:
Fentanyl, Ativan 2 > both prior to arrival. Pt vomited prior to EMV on scene
Norcuron

Past Medical History: ☐ Check if complete PMH cannot be obtained due to need for urgent evaluation and/or urgent management of patient's condition

Medications: ∅

Allergies: A relative on the scene stated that he has no medical condition.

Previous Surgeries:

Chronic Medical Conditions:

Primary Care Physician: ∅

Social History: ☑ Check if complete Social History cannot be obtained due to need for urgent evaluation and/or urgent management of patient's condition

EtOH use: ? - able to smell EtOH on patient

Tobacco Use: ?

Drug Use: ?

Employment: ?

Family History: ☑ Check if complete family history cannot be obtained due to need for urgent evaluation and/or urgent management of patient's condition

Injury List

	Injury	AIS Code
1.	(B) big toe fracture	
2.	(R) 5th toe fracture + all R toes	
3.	Fracture of skull midline to sagittal	
4.	Hough frontal/ parietal	
5.	Subdural / epidural fluid collection	
6.	(B) frontal contusion	
7.	R scapula fracture	
8.		
9.	Hypotension	
10.	deep hemorrhage anemia	
11.	Scalp lac - large complex S/P repair	
12.	C7 + T1 Spinous process Fx	
13.	R Rib Fx 7, 8, 9, 10	
14.	B/L transverse process fracture L1 + L2; Right C5	
15.		

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HISPHYS

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Trauma Center Initial Patient Evaluation
Page 2 of 6

P490943644 DOB:01/01/1851 U U
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HISTORY (continued)

Review of Systems: ☑ Check if complete ROS cannot be obtained due to need for urgent evaluation and/or urgent management of patient's condition
(* If no notation, system was not evaluated)

System*	WNL	Abnormal (describe)
(Constitutional) Overall health	☐	
Eyes	☐	
Ears, nose, throat, mouth	☐	
Cardiac	☐	
Vascular	☐	
Respiratory	☐	
Gastrointestinal	☐	
Genitourinary	☐	
Musculoskeletal	☐	
Skin/breasts	☐	
Neurologic	☐	
Psychiatric	☐	
Endocrine	☐	
Hemotologic/lymphatic	☐	
Immunologic	☐	

PRIMARY SURVEY (INITIAL FINDINGS)

Airway:
☑ Patent and stable
☐ Unstable (explanation): - pt arrived intubated
Actions taken:

Breathing:
☑ Breath sounds clear bilaterally, no respiratory compromise or distress
☐ Abnormalities (describe):
Actions taken:

Circulation:
☑ No signs/symptoms of shock; no external hemorrhage
☐ Abnormalities (describe):
Actions taken:

Disability:
☐ No abnormalities
☑ Abnormalities (describe): unable to respond
Actions taken:

RESUSCITATION: (Check all that apply including actions taken during entire Emergency Department evaluation)
☑ Peripheral Intravenous Lines Placed (see nursing notes for locations) RFA & LAC 16 gauge both) 16 gauge in ⓛ hand
☐ Chest Tube placed: (location): _____ (See procedure note(s) for specific details and nurses notes for total output)
☐ Chest Tube #2 placed: (location): _____ (See procedure note(s) for specific details and nurses notes for total output)
☐ Central Venous Line placed: (location): _____ (See procedure note(s) for specific details)
☐ Central Venous Line #2 placed: (location): _____ (See procedure note(s) for specific details)
☐ Foley Catheter placed
☐ ☐ NG / ☐ OG Tube placed (check as appropriate)
☐ ECG monitor placed
☐ Patient placed on supplemental O_2
☐ Patient placed on ventilator
_____ Mode _____ F_iO_2
_____ PEEP/CPAP _____ V_T _____ Rate
☐ End Tidal CO_2 Monitor placed
☐ Pulse Oximeter placed
☐ Other: _____

OTE 800038 Rev. 7/04

* H I S P H Y S *

MUSC
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Trauma Center Initial Patient Evaluation
Page 3 of 6

P490943644 DOB:01/01/1851 U U
TRAUMA
VICTIM JW
Adm:00000000 M2581962

PHYSICAL EXAMINATION
Initial Vital Signs: BP: 141/79 → 80/34 → 112/62 Pulse: 116 Resp. Rate: 24 on PRVC Temperature: 96.4

Initial GCS: Eye Opening: 1 pts
Verbal Response: [illegible] pts
Motor Response: 1 pts
Total GCS Score: 3T pts

unable to quantify 2° to intubation + sedation

97% - intubated

Part Examined	WNL	Abnormal (describe)
General	☐	
Head		
Scalp	☐	6 inch front to back open laceration with aponeurosis exposed
Facial Skin	☐	
Facial Bones	☐	
Mandible	☐	
Eyes		
Pupils	☐	unreactive, but pt received fentanyl, rocuron, + etiv @ 1605, but pinpoint + equal
EOM	☐	
Fundi	☐	
Ears		
TM's	☑	
Ext Aud. Canals	☐	
Pinna	☐	
Nose		
Nasal Septum	☐	
Mouth		
Teeth	☐	
Tongue	☐	swollen
Pharynx	☐	
Hard/soft Palate	☐	
Neck		
Bony Spine	☐	- pt is in a miami - J collar
Soft Tissues	☐	
Chest		
Breath Sounds	☑	CTA (B)
Chest Wall	☐	
Heart	☐	
Abdomen	☐	soft
Pelvis	☐	stable
Genitalia	☐	foley placed
Rectum/Perineum		
Prostate	☐	
Sphincter Tone	☑	
Stool Gross Blood	☐	
Back	☑	

* H I S P H Y S *

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Trauma Center Initial Patient Evaluation
Page 4 of 6

P490943644 DOB:01/01/1851 U U
TRAUMA
VICTIM JW
Adm:00000000 M2581962

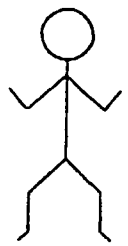
Vascular Examination			
Vessel	Lt	Rt	Comments
Carotid	✓	✓	
Brachial			
Radial			
Ulnar			
Femoral	✓	✓	
Popliteal			
Dorsalis Pedis	✓	✓	
Posterior Tibial	✓	✓	

Extremity Examination		
Extremity	WNL	Abnormalities (describe)
Left Clavicle	☐	
Right Clavicle	☐	
Left Upper Arm / Shoulder	☐	
Right Upper Arm / Shoulder	☐	abrasion = 3x 4cm - "road rash" - abrasion
Left Forearm	☐	
Right Forearm	☐	~~abrasion~~
Left Hand	☐	
Right Hand	☐	
Left Thigh / Hip	☐	
Right Thigh / Hip	☐	
Left Calf / Knee	☐	
Right Calf / Knee	☐	
Left Foot / Ankle	☐	
Right Foot / Ankle	☐	bleeding from 4th toe + swelling. crepitus with movement (by physician) of all toes

NEUROLOGIC EXAMINATION:

Motor Strength						
Muscle Group	0	1	2	3	4	5
Biceps						
Triceps						
Grip Strength						
Quadriceps						
Ileopsoas						
Foot Plantar Flexion						
Foot Dorsiflexion						

☐ Check if unable to assess motor strength due to patient's inability to cooperate with exam



Reflexes

Sensory Examination: ☐ Intact Overall ☑ Unable to examine due to patient's inability to cooperate with exam
☐ Deficits (describe): _____

Cranial Nerves (II-XII): ☐ Intact Overall ☑ Unable to examine due to patient's inability to cooperate with exam
☐ Deficits (describe): _____

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Trauma Center Initial Patient Evaluation
Page 5 of 6

P490943644 DOB:01/01/1851 U U
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Adm:00000000 M2581962

ADDITIONAL PHYSICAL FINDINGS:

INR 1.4

LABORATORY STUDIES: PT: 17.7 PTT: _____ Platelet: 209 HCG: ϕ

15.1 / 10.3 / 30.7 < 209 | 143 | 113 | 13 / 3.9 | 23 | 1.2 < 171

Serum osmol 437

Other Laboratory Studies:
Lytes ordered given in ER

ADDITIONAL STUDIES: (Results based on preliminary verbal reports available at time of initial viewing)

CXR:	☐ Not performed	☐ WNL	☐ Abnormal (describe):	right clavicle fx
C-Spine:	☐ Not performed	☐ WNL	☐ Abnormal (describe):	
T-Spine:	☐ Not performed	☐ WNL	☐ Abnormal (describe):	
L-Spine:	☐ Not performed	☐ WNL	☐ Abnormal (describe):	
Pelvis:	☐ Not performed	☐ WNL	☐ Abnormal (describe):	
(R) foot — Extremities:	☐ Not performed	☐ WNL	☐ Abnormal (describe):	multiple phalangeal fx - open
Abd. U/S:	☐ Not performed	☐ WNL	☐ Abnormal (describe):	
CT Head:	☐ Not performed	☐ WNL	☐ Abnormal (describe):	Skull fracture, epidural hematoma (R) frontal contusions
CT Abd:	☐ Not performed	☒ WNL	☐ Abnormal (describe):	
CT Chest:	☐ Not performed	☐ WNL	☒ Abnormal (describe):	B/L lung contusions, R overriding clavicular Fx
CT C-spine:	☐ Not performed	☐ WNL	☒ Abnormal (describe):	Fx ant body of C7 & T1 spinous process Fx

(R) Foot x-ray series — 1st thru 5th phalanges fractures.

Other Ancillary Studies Performed (describe study and results):
FAST; negative
→ CT chest: B/L transverse process Fx L1, L2; Right L3 & Rib Fx 7, 8, 9, 10
→ CT Head - Skull Fx c signif diastases extending longitudinally from occipital bone into parietal, temporal, + frontal bone extending obliquely thru orbit roof

Diagnoses/Injuries: Skull fx, open - large complex scalp laceration c/w avulsion
(R) frontal contusions, epidural & subdural hematoma / subdural hematoma

Management options were discussed with physicians from the following services:
☒ Orthopaedic Surgery ☑ Neurosurgery ☐ Facial Surgery ☐ Trauma Surgery ☐ CT Surgery
☐ Others (list): _____

Physician Signature: [signature] ☑ Resident ☐ Attending
Service: Trauma Pager ID: 15469 Date: 11 / 1 / 07

OTE 800038 Rev. 7/04

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Trauma Center Initial Patient Evaluation
Page 6 of 6

P490943644 DOB:01/01/1851 U U
TRAUMA
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MUSC Trauma Center Initial Patient Evaluation

Attending Physician's Statement

Attending Statement: The patient has been seen and examined by me personally. I have reviewed the house staff documentation above and a discussion of the history and physical findings has been held.

I can confirm the following key history factors: 27yo ♂ hit in head w/ part of roof/crane +LOC at scene, significant blood loss, nervous at scene intubated by EMS.

I have examined the patient and key findings include: complex scalp lac 20 inches. Skull fx epidural/subdural hematoma. R clavicular fx, multiple R phalanges fx

I have personally reviewed all available radiographic images: ☑ Yes ☐ No

Assessment (see page 5 for complete diagnosis list): 27yo ♂ s/p skull fx, open complex scalp wound washed out and closed in Trauma Bay - epidural/subdural hematoma (B) frontal contusions

Plan: Admit to ICU: NSP failure: CNS recent support - Dilantin for IVF hydration, serial hematocrits to evaluate acute hemorrhagic anemia, maintain MAP > 80 to improve CPP; consult neurosurgery and other recommendations

I spent 1½ hours evaluating pt and reviewing films

Patient Condition: ☑ Critical/Unstable ☐ Serious ☐ Fair ☐ Good

This document is serving as:
☑ Admission History and Physical ☐ Emergency Dept. Evaluation ☐ Consultation (service consulting): _____
☑ Critical Care Services (Total time spent with patient, family, and reviewing data: 1½ hours)

Signature: _____ Attending Physician Pager ID: 14195
Date: ____/____/____

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VICTIM JW
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 1 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # /

	0	1	2	3	4	5	S
PED							
ADULT	0	2	4	6	8	10	SLEEPING
	NO HURTS	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORSE	

1 2 3 4 5 6 7 8 9MM

TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S_{O_2}	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL / EYES
08																				
09																				
10																				
11																				
12																				
13																				
14																				
15																				
16																				
17																				
18																				
19	36.9	107	RE / 36	115/55		69					100		pt Admitted	UTA 3	3	3	5	5	ET	1
20	37.1	114	26	115/57		68					100		2045: Code Drest	UTA 3	3	3	5	5	ET	1
21	37.4	100	1 / 18	108/66		77					100									
22	37.8	106	3 / 18		147/46	106					100		A-line placed 2145	UTA 3	3	3	5	5	ET	1
23	38.2	108	6 / 18		148/84	106					100			UTA 3	3	3	5	5	ET	1
24	38.2	112	2 / 18		150/84	104					100			UTA 3	3	3	5	5	ET	1
01	38.5	113	2 / 18		153/84	104					100			UTA 3	4	4	5	5	ET	3
02	38.5	106	18		147/83	103					100		NS Rounds	UTA 3	4	4	5	5	ET	3
03	38.2	101	18		139/79	93					100		0630 Hecta / Ebram	UTA 3	4	4	5	5	ET	3
04	37.8	107	16		136/76	93					100			UTA 3	4	4	5	5	ET	3
05		105	18		132/75	92					99			UTA 3	4	4	5	5	ET	3
06	37.4	92	18		135/76	95					100			UTA 3	4	4	5	5	ET	3
07	37.4	101	18		126/71	82					98		CC Rounds	UTA 3	4	4	5	5	ET	3

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 01 2007

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials

UP# 411230 rev 8/03

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 1 2007

page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	Propofol 10mg/ml	Ns c 20mg KCl/L x 1L	Fentanyl 50 mcg/ml	Midaz	KCL 10meq/100ml	A-line Flush	BLOOD PRODUCTS COLLOIDS FFP	PRBC	NUTRITION TYPE	PO	TUBE	INTAKE TOTALS HRLY TOTAL	CUM TOTAL
08													
09													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20													
21	24.5 / 24.5						325 / 325					350	350
22	29.4 / 54					3 / 3	518 / 518	300 / 300				627	977
23	19.9 / 83	125 / 125				3 / 6		300 / 600				454	1421
24	39 / 111	125 / 250	25 / 5			3 / 9						158	1579
01	29 / 141	125 / 375	1 / 2	100 / 100		3 / 12						258	1837
02	29 / 170	125 / 500	1 / 3			3 / 15						158	1995
03	29 / 199	125 / 625	1 / 4			3 / 18						158	2153
04	29 / 228	125 / 750	1 / 5			3 / 21						158	2311
05	29 / 257	125 / 875	1 / 6		100 / 100	3 / 24						258	2569
06	19.6 / 277	125 / 950	1 / 7	100 / 100	100 / 100	3 / 27						349	2918
07	19.6 / 297	125 / 1075	1 / 8			3 / 30						149	3067

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NOV 0 1 2007

P:490943644 DOB:01/01/1851 L M
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VICTIM JW
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

1950 Pt Admitted to BT ICU Room 4. Corrected To Monitor, ST Noted To Monitor. Philly Collar in Place. Pt localises To Pain. Propofol started @ 50mcg/kg/Min. Pupils PERRL. See flowsheet for Physical Assessment Details. MW 2045 Otho Present @ Bedside (R) foot Cast Placed MW 2145 (L) Rad A-Line Placed 2200 Dr. Brown Aware of H+H. orders Received MW 2330 Dr. Brown Aware of Present Labs MW 0200 NS Bounds Neuro Assessment Performed by Dr. Krishna. MW 0430 Dr. Brown Aware of Current Labs. Dr. Brown Performed a Rectal Exam on Pt MW 0700 Cc from NS Kept Given MW

UP# 411200 rev 8/03

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 01 2007

page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE		GASTRIC				CHEST TUBES / DRAINS								BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	Foley		STOOL	EMESIS	OG/NG	RESID										
08																		
09																		
10																		
11																		
12																		
13																		
14																		
15																		
16																		
17																		
18																		
19																		
20	350		350															
21	450		100															
22	575		125															
23	750		175															
24	900		150															
01	1025		125															
02	1150		125															
03	1275		125															
04	1335		60															
05	1385		50															
06	1425		40															
07	1485		60															

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 1 2007

SAFETY

- ☒ Hospital ID band on ☐ Allergy band on
- ☐ Call system accessible
- ☒ Bed in low position ☒ Bed brakes on ☒ Bed alarms on
- ☒ Bed heel pressure relief ☐ On ☐ Off reason: _____
- ☒ IV solutions verified
- ☒ IV tubing/bag dated
- ☒ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status ☐ Violent behavior
  - ☐ History of falls ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances ☐ Other _____
- ○ Any risk criteria identified, implement the **Safety** section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	(<59)	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose Sedated	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/fx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below
SUBTOTAL:	0	2	0	3
TOTAL POINTS:	5	☐ N/A Patient < 6 years old		

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement **Safety** section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE	Placed 2145			0300 MW	
TRACH CARE					
BATH	2200 MW				
FOLEY / PERI CARE	2200 MW				
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE	2200 MW				
SKIN CARE					
PEG SITE CARE					
TYPE OF DIET	NPO				
% EATEN	NPO				
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 01 2007

page 4 of 12

2100
Ion Ca - 1.61

2330
Ion Ca - 1.09

0300
Ion Ca - 1.15
HGB A1C - 5.5

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES				HEMATOLOGY					CHEMISTRY								
TYPE O2 DEL	MODE RATE	FiO2 TV	PEEP PS	CPAP PIP	MEAN VENT		A/V PH	PO2 PCO2	HCO3 O2SAT		HCT HGB	WBC RBC	PT PTT	PLT INR		NA K	CL CO2	GLUC BUN	CREAT CA	MG PHOS		FSBS	
																							08
																							09
																							10
																							11
																							12
																							13
																							14
																							15
																							16
																							17
																							18
																							19
Vent	DAC TC	60 50	5								A 7.2 6.6	5.3 2.21	16.4 28.1	100 1.47		146 3.8	113 24	92 10	1.1 64	1.5 4			20
SD Vent		VAP					A 7.38	22.1 40	23.2 99		17.3 6	4.3 2.06		88									21
						2300																	22
							A 7.35	28 41	23.2 95		26.8 9	3.5 3.1		77									23
																							24
0140	DAC TC	50	8																			105	01
																							02
							A 7.58	28 42	23.9 97.6		23.9 89	4.3 3.03	16.4 30.1	93 2.27		144 2.9	113 25	102 9	1.1 2.8	1.5 3.2			03
																						105	04
																							05
																							06
																							07

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 1 2007

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter — Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line — Date inserted: 11/1/07

	Appearance	Location	Dressing	Calibrated Time	
A					
P	S	(L) Rad	DIT	2145	(+) WF (+) KR

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: #14 — Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A				
P	(R) AC	S	DIT	(+)

Line #2 Type: #16 — Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A				
P	(L) Hand	S	DIT	(+)

Line #3 Type: #16 — Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A				
P	(R) FA	S	DIT	(+)

Line #4 Type: _____ — Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

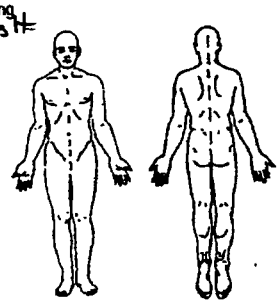
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☒P Pain ☐A ☒P Receiving analgesic therapy Fentanyl 3H

(A) Pain Score: _____ *Patient Goal:* _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



○ Any problems identified, implement **Comfort** section of the **POC.**

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

- ☒ **Psychosocial / Spiritual / Education** A____ P M
- ☒ **Comfort** A____ P M
- ☒ **Neurologic / EENT** A____ P M
- ☒ **Safety** A____ P M
- ☒ **Functional / Musculoskeletal** A____ P M
- ☒ **Skin / Wound** A____ P M
- ☒ **Cardiovascular** A____ P M
- ☒ **Respiratory** A____ P M
- ☒ **Gastrointestinal** A____ P M
- ☒ **Genitourinary** A____ P M
- ☒ **Nutrition** A____ P____
- ☐ **Discharge Planning** A____ P____
- ☐ **Other** _____ A____ P____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT

SIGNATURE _____ TIME _____

PM SHIFT ASSESSMENT

SIGNATURE [signature] TIME 1950

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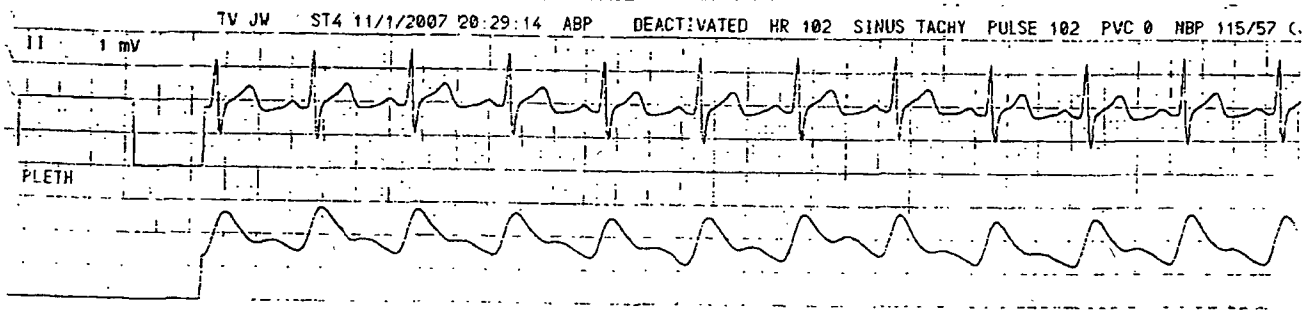
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page 5 of 12

THIS SPACE MONITOR STRIPS



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page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM PTA

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☒ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm)_____
☐ A ☐ P Hernia, site_____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT		✓ A side	LC	LC		GR
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						
		–				

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

☒ Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other_____

Tubes / devices
☐ A ☐ P Condom ☐ A ☒ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A_____ P_____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
☒ Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date_____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness		X		X		X		X
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location_____

Devices Site / Type
☐ A ☒ P SCD/foot pump LLE
☐ A ☐ P TED
☐ A ☐ P Traction
☐ A ☐ P Cast/splint
☐ A ☐ P External fixator
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ☐ A ☐ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale; ☐ A ☐ P Cyanotic; ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose; ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool; ☐ A ☐ P Diaphoretic

Skin Impairments Location
☐ A ☐ P Surgical incision_____
dressing type/appearance_____
☐ A ☐ P Drain_____
☐ A ☐ P Drain_____
☒ A ☒ P Wound (C) Head LCC
dressing type/appearance Sutures DTA
☒ A ☐ P Other (R) Foot LAC
☐ A ☒ P Other (L) Hand LAC

Wound vac™

	Location	mmHg	Suction
A			
P			

○ Any problems identified implement **Skin/Wound** section of the **POC.**

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SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location (L) Head
☒ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☒ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☒ Bloody ☐ Odor
Surrounding skin
☒ Normal ☐ Erythema ☐ Induration
☐ Other
Dressing change 2200 Cleaned Time
Dressing type OTA

Surgical Incision #2 Location (L) Rad A-Line
☒ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☒ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☒ Normal ☐ Erythema ☐ Induration
☐ Other
Dressing change 0300 Time
Dressing type Clear Dressing

Wound #1 Location
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length ____ cm
Width ____ cm
Depth ____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined ____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other ____
Dressing change ____ Time
Dressing type ____

Wound #2 Location
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length ____ cm
Width ____ cm
Depth ____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined ____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other ____
Dressing change ____ Time
Dressing type ____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	20	22	24	02	04	06						
Suction/cough / Secretions	St Th,T	St Th,T	St Th,T	St Th,T	St Th,T	St Th,T						
HOB>30 degrees unless contraindicated	✓	✓	✓	✓	✓	✓						
A line site ✓	✓	✓	✓	✓	✓	✓						
IV site ✓	✓	✓	✓	✓	✓	✓						
Chest tube patent ✓	→	→	→	→	→	→						
NG/OG place ✓	1 A.Cath →	→	→	→	→	→						
Mouth care	✓	✓	✓	✓	✓	✓						
Turn / Passive ROM	✓	✓	✓	✓	✓	✓						
Side Rails	TX2 →	→	→	→	→	→						
Incen. Spir./ deep breathe	Vent →	→	→	→	→	→						
Alarms on / Assessment reviewed	✓ MN	MN	N	✓ MN	✓ MN	✓ MN						

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NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☐ A ☒ P Chemical paralysis/sedation Propofol gtt

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A				
P	1	1	1	1

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:						
	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☐ A ☒ P Cervical collar Philly

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☐ A ☒ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

☒ Any problems identified, implement **Neurologic / EENT** section of the **POC.**

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐ A ☒ P Arrhythmia ST

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A				+1	Facial
P					

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P					

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

☒ Any problems identified, implement **Cardiovascular** section of the **POC.**

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☐ A ☒ P: Suction functioning

☐ A ☒ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R		R	
P					

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	6.5		24cm
P				

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☒ Any problems identified, implement **Respiratory** section of the **POC.**

* N R S R E C R D *

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HECTOR
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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

(STAMP PLATE)

TIME	IV SOLUTIONS / ADDITIVES: NS c 20 MEQ KCl	BLOOD PRODUCTS COLLOIDS	NUTRITION: TYPE	NUTRITION: PO	NUTRITION: TUBE	INTAKE TOTALS: HRLY TOTAL	INTAKE TOTALS: CUM TOTAL
08	10 10		promote	40 40	70 70	120	120
09	10 20				70 140	80	200
10	10 30				70 210	80	280
11	10 40				70 280	80	360
12	10 50			30 70	70 350	110	470
13	10 60				70 420	80	550
14	10 70				70 490	80	630
15	10 80				70 560	80	710
16	10 90				70 630	80	790
17	10 100				70 700	80	870
18	10 110			30 70	70 770	110	980
19	10 120				70 840	80	1060
20	10 130				70 910	80	1140
21	10 140				70 980	80	1220
22	10 150				70 1050	80	1300
23	10 160				70 1120	80	1380
24	10 170			80 80	P 1190	140	1520
01	10 180				70 1260	80	1600
02	10 190				70 1330	80	1680
03	10 200				70 1400	80	1760
04	10 210				70 1470	80	1840
05	10 220				70 1540	80	1920
06	10 230				70 1610	80	2000
07	10 240				70 1680	80	2080

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(STAMP PLATE)

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

TIME	OUTPUT CUM	OUTPUT HOURLY	URINE (10a)	GASTRIC STOOL	GASTRIC EMESIS	GASTRIC OG/NG	GASTRIC PEG RESID	CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
08	75	75	75				0			
09	155	80	80							
10	230	75	75							
11	305	75	75							
12	405	100	100							
13	440	75	75							
14	565	125	125				0			
15	665	100	100							
16	775	110	110							
17	865	90	90							
18	940	75	75							
19	1030	90	90							
20	1130	100	100				0			
21	1205	75	75							
22	1280	75	75							
23	1335	55	55							
24	1395	60	60				0			
01	1455	60	60							
02	1505	50	50							
03	1535	30	30							
04	1585	50	50				0			
05	1635	50	50							
06	1685	50	50							
07										

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____ (STAMP PLATE)

page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0720 Report received from PM RN, standards of care reviewed, plan of care cont. 0730 Assessment comp. as noted, pt. follows commands c B/E, denies pain @ this time, will cont. to monitor. 0900 NO Δ's @ this time. 1100 cc team @ BS for rounds, orders received + noted. 1300 NO Δ's @ this time. 1400 OT @ BS. 1600 RT @ BS for resp. treatmt. 1800 NO Δ's @ this time. 1900 Report given to PM RN, pt. left attended.

1915 Report received, pt care assumed. Orders reviewed. ~~Assessment started~~ 2000 Assessment Complete and charted. Pt follows commands c B/E c c/o pain diluadid given 2mg IV See MAR and Pt agitated during IPV Haldol given. Will continue to monitor. 2200 Pt sleeping @ this time. ↓ Changes in assessment 2345 Pt watching TV c/o pain See MAR ↓ Δ's noted 0300 Comfort bath given Linens Δ'd. new tube feeding bag 0500 ↓ Δ's noted 0715 Report given to oncoming RN. Orders reviewed

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(STAMP PLATE)

SAFETY

- ☒ Hospital ID band on
- ☐ Allergy band on
- ☒ Call system accessible
- ☒ Bed in low position
- ☒ Bed brakes on
- ☐ Bed alarms on
- ☒ Bed heel pressure relief
- ☒ On ☐ Off reason: _____
- ☒ IV solutions verified
- ☒ IV tubing/bag dated
- ☒ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ Violent behavior
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other _____
- ○ Any risk criteria identified, implement the **Safety** section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:	0	2	0	0
TOTAL POINTS:	2	☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement **Safety** section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					
TRACH CARE	1500 OK				0800 OK
BATH	partial OK				0800 OK
FOLEY / PERI CARE	1500 OK				0800 OK
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE	1500 OK				0800 OK
SKIN CARE					0800 OK
PEG SITE CARE	1500 OK				0800 OK
TYPE OF DIET	TF				TF
% EATEN					100% NT
PACING WIRES INSULATED SECURED					
SPECIALTY BED	ICU				ICU

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* N R S R E C R D *

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

(STAMP PLATE)

page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION					BLOOD GASES			HEMATOLOGY					CHEMISTRY								
TYPE O_2 DEL	MODE / RATE	FIO_2 / TV	PEEP / PS	CPAP / PIP	MIN VENT	AN / PH	PO_2 / PCO_2	HCO_3 / O_2SAT	HCT / HGB	WBC / RBC	PT / PTT	PLT / INR	NA / K	CL / CO_2	GLUC / BUN	CREAT / CA	MG / PHOS		FSBS		
T		50%																	133		08
																					09
																					10
																					11
																			143		12
																					13
																					14
																					15
																			133		16
																					17
																					18
																					19
TC	50%																		122		20
																					21
																					22
																					23
																			119		24
						A 7.4	102 47	82 95	38.7	11.3 8.9	3.5	5.2	33	3.4 97	7.1	142	4.1	106	30	109	15	0.5	9.7	8.4	4.7		01
																					02
																					03
																					04
																					05
																					06
																					07

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: __/__/__

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: __/__/__

	Appearance	Location	Dressing	Calibrated Time
A				
P				

High Dose Heparin catheter Type: _____ Date inserted: __/__/__

	Appearance	Location	Dressing
A			
P			

Line #1 Type: DLC Insert Date: 11/17/07

	Site	Appearance	Dressing	Blood Return
A	(L) SC	S	D/I	+
P	(L) SC	scale	D/I	+

Line #2 Type: _____ Insert Date: __/__/__

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: __/__/__

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: __/__/__

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

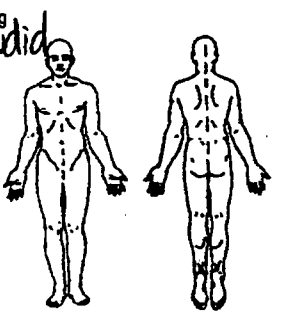
☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☒A ☒P Receiving analgesic therapy prn dilaudid
(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling



Location of pain (on the diagram, put an X on the area where the patient complains of pain)

● Any problems identified, implement **Comfort** section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☒ Psychosocial / Spiritual / Education	M	M
☒ Comfort	M	M
☒ Neurologic / EENT	M	M
☒ Safety	M	M
☒ Functional / Musculoskeletal	M	M
☒ Skin / Wound	M	M
☒ Cardiovascular	M	M
☒ Respiratory	M	M
☒ Gastrointestinal	M	M
☒ Genitourinary	M	M
☒ Nutrition	M	M
☐ Discharge Planning		
☐ Other _____		

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
Heathman RN — SIGNATURE — 0730 — TIME

PM SHIFT ASSESSMENT
[signature] — SIGNATURE — 2015 — TIME

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NRSRECRD

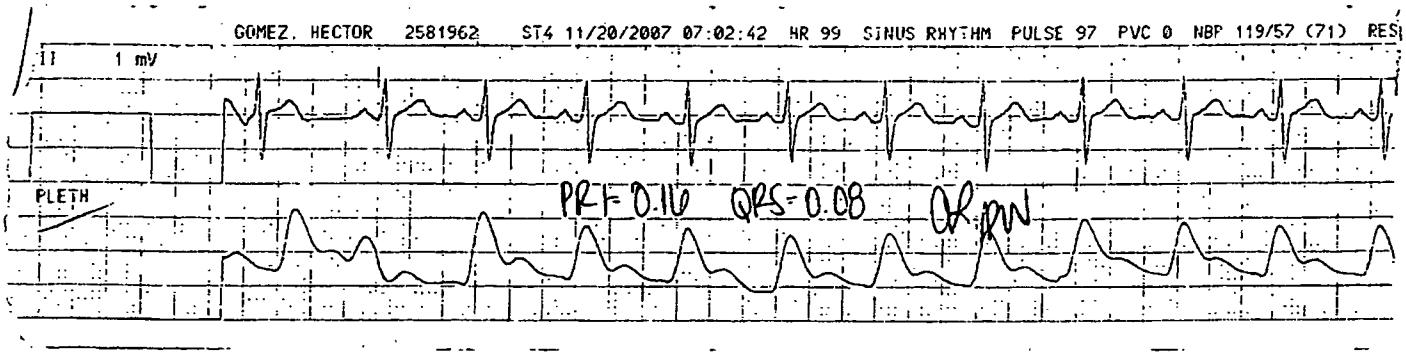
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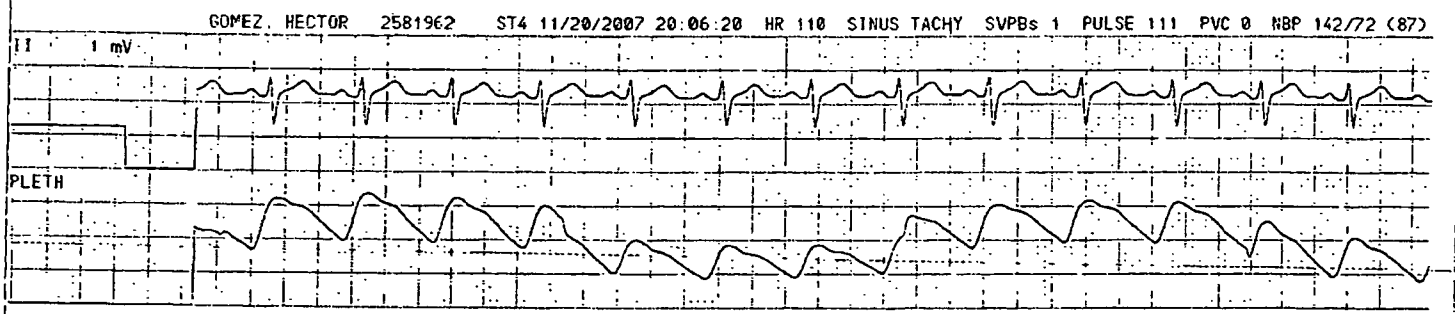
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page 5 of 12





UP# 411230 rev 8/03

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page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM 11/14/07

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☒ A ☒ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓=placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT						
Small bore feeding tube						
G-tube	✓	(B)	—	—	F	F
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

● Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☒ A ☒ P Hematuria
☐ A ☐ P Foul odor (A) times
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P Condom ☒ A ☒ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete Uterine/Fetal section)
● Any problems identified, implement Genitourinary section of the POC.

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness								
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Site / Type
☒ A ☒ P SCD/foot pump (B) LE
☐ A ☐ P TED _____
☐ A ☐ P Traction _____
☐ A ☐ P Cast/splint _____
☐ A ☐ P External fixator _____
☐ A ☐ P Other _____

Speech
☐ A ☐ P Slurred ☒ A ☒ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
● Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin Impairments Location
☐ A ☐ P Surgical incision _____
dressing type/appearance _____
☐ A ☐ P Drain _____
☐ A ☐ P Drain _____
☒ A ☒ P Wound (F) toes - necrotic
dressing type/appearance Head foc sutures
☐ A ☐ P Other _____
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

● Any problems identified implement **Skin/Wound** section of the **POC.**

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SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	2000	2200	2400	0200	0400	0600
Suction/cough / Secretions	S TN, W	S TN, W	S TN, W	S TN, W	S TN, W	S TN, W	S TRP	S TH, Y	S TH, W	S TH	S TH, W	S TH, W
HOB>30 degrees unless contraindicated	✓	✓	✓	✓	✓	✓						
A line site ✓	N/A	—	—	—	—	—	N/A	—	—	—	—	—
IV site ✓	✓	✓	✓	✓	✓	✓						
Chest tube patent ✓	N/A	—	—	—	—	—	N/A	—	—	—	—	—
NG/OG place ✓	PEG	—	—	—	—	—	PEG	—	—	—	—	—
Mouth care	✓	✓	✓	✓	✓	✓						
Turn / Passive ROM	✓	✓	✓	✓	✓	✓						
Side Rails	X2	X2	X2	X2	X2	X2						
Incen. Spir./ deep breathe	self	self	self	self	self	self	self	self	self	self	self	self
Alarms on / Assessment reviewed	✓	✓	✓	✓	✓	✓						

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(STAMP PLATE)

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA

☐ A ☐ P **WNL:** Fontanel soft and flat. follows commands

Abnormal Findings

☒ A ☒ P Glasgow coma scale < 15 in non-sedated state.
☐ A ☐ P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A				
P	(	(	(	(

Reflexes Absent
☐ A ☐ P Cough ☐ A ☐ P Gag
☐ A ☐ P Corneal

Drainage
☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea
☐ A ☐ P Eye
1- clear 2-cloudy 3-bloody

Drain Type:

Location:						
	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices
☒ A ☐ P Cervical collar Miami J
☐ A ☐ P Cervical traction
☐ A ☐ P Halo
☐ A ☐ P Tongs
☐ A ☐ P Shunt: _____
☐ A ☐ P Codman reference # _____
☐ A ☐ P Other _____

Impairments
☐ A ☐ P Hearing
☐ A ☐ P Eyes
☐ A ☐ P Unable to assess

Fontanel
☐ A ☐ P Full ☐ A ☐ P Bulging
☐ A ☐ P Sunken

Emotional status
☐ A ☐ P Inconsolable

● Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart
☒ A ☐ P Arrhythmia ST | SP
☐ A ☐ P Click
☐ A ☐ P S3
☐ A ☐ P Distant heart sounds
☐ A ☐ P S4
☐ A ☐ P Rub
☐ A ☐ P Capillary refill > 3 sec.

Murmur
☐ A ☐ P Faint
☐ A ☐ P Moderate
☐ A ☐ P Loud
☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A					
P					

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P					

Pacemaker / wires
☐ A ☐ P Permanent ☐ A ☐ P Transvenous
☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial
Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter
☐ A ☐ P AICD

● Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☒ A ☐ P: Suction functioning
☒ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations
☐ A ☐ P Labored ☐ A ☐ P Shallow
☐ A ☐ P Irregular ☐ A ☐ P Orthopnea
☐ A ☐ P Stridor ☐ A ☐ P Pleural rub
☐ A ☐ P Accessory muscle use
☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation
☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	D	R	D
P	R	R	D	R	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	T	8.0	WNL	
P	Trach	8.0	WNL	

☒ A ☒ P Emergency trach supply box
☒ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage
S=serous; SS=serosanguinous; B=bloody; P=purulent
Air leak / SQ emphysema
P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

● Any problems identified, implement **Respiratory** section of the POC.

UP# 411230 rev 8/03

PRGRECRD

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3 Version Date: 9/06

P490943644 DOB:01/01/1851 U U
TRAUMA
VICTIM JW
Adm:00000000 M2581962

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
		Ortho Consult
11/1/05	2100	Briefly: HM hard a crane fall on him c work
		⇒ open head injury. Ortho consulted for (R)
Full consult dictated		clavicle fx + (R) foot frx.
		PE:
		Intubated/Sedated. Moved all extremities upon admission per trauma team
		RUE: (+) crepitus c clavicle
		ϕ deformities or crepitus c shoulder, arm, elbow, forearm or hand
		(R) swelling over dorsum of (R) hand
		2+RP
		LUE: ϕ crepitus/bony deformities, 2+RP
		Pelvis: stable to lat + AP compression
		LLE: ϕ crepitus or bony deformity
		Full PROM hips
		2+ DP
		RLE: CR < 2sec
		Traumatic arthrotomy of 4th/5th digit
		Xrays: (R) clavicle fx
		(R) dist phalanx comminuted fx
		(R) 2-5th prox phalanx fx, 4/5 open
		A/P ltm c plans of the possible injuries plus epidural/stable bleeds L-5 TP fxs, Rib fxs
		- (R) foot washed out @ bedside. To OR for formal I+D when stable
		- Ancef IV q8°
		- Splint RUE

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OTE 700222 Rev. 9/06

1525

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
Patient Name GOMEZ, HECTOR
MRN Adm:11/01/07 M:2581962

STAMP PLATE AREA

162

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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

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Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/1/07	9:14	STHU R, RN

S: 56y/o Hispanic male was hit in the head by a construction crane while working at construction worksite. The patient was found down c LOC (), while being transported pt had emesis x 1 & was intubated in ED & was combative c SpO2 on breath per EMS. Pt was sent to Fast Scan & found to have intracranial bleed, several Rt foot fx's, ribs fx, scalp lac, & assumed vertebral body fx's c @ Frontal contusion. Pt arrived to STHU in Guarded condition

O: Vitals

Neuro: GCS 7T, Withdraws from pain & per nursing moved all extremities in ED

HEENT - Lt Scalp laceration in hair region (sutured), PERRLA

CV: S, S, @ NSR

Lungs: Pt has expiratory wheezing

Abd: BS(+), Soft NT/ND

Extremities: Rt foot (LLE) casted c good cap refill, 2+ DP, c Minor Abrasions on all extremities

Labs: 146 | 117 | 10 / (97) 4.3 / 60 / H / ACT 100 & 220 | FIO2 60% 7.346 | 40 | 22 | /PM | 22)
3.8 | 24 | 1.1 Bili 1.5 | 129 | 14.2 | 24.9 | Osmolality = 437

A/P: 56y/o Hispanic male c Epidural hematoma, @ Frontal contusion, Rt hip fx & 5th per fx, Open laceration scalp wound, C7-T1 SP fx's, Lt T1 TP fx, Rt thumb fx's, Skull fx's, & Multiple rib fx's now intubated & sedated

1. Neuro: Pt would localize to pain, Will cont the Neuro checks Will reassess Neurologic Exam
2. Cardio: Pt stable & mildly tachy, Will Place Holter for HR monitoring & Hypotensive PRN 7 HR 140
3. Resp: Pt Intubated & Sedated will wean ventilator settings as able & ABG trends tomorrow AM
4. GI - Pt Heme (-), in ED, Will keep NPO at MN
5. Renal: Foley in place, Stable Good UOP
6. FEN - Pt on
7. Endo - SSI
8. Heme - PRBC & Platelets count today will recheck H&H & transfuse if < 30, maintain Pt
9. SCD's for DVT & PPI for GI
10. Pt on Cefotaxime & Vanc for Skull fx

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OTE 700222 Rev. 9/06

(531)

PRGRECRD

MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3 Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

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Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/2/07		STICU / CC
	0725	No events
		38.5 37.4 101 126/71
		4103067 / 1485
		Propofol gtt / NS ± 20 KCl / Fentanyl gtt / Claforan / Vanc
		Sedated → propofol d/c'd → E4 Vt M6
		Moves all extremities, localizes
		PERL
		Does not f/c in English or Spanish
		144 | 113 | 9 — 102 — 4.3 — 9 — 16.4 — Id — 29 | 25 | 1.1 — 3.2 — 25.9 — 1.7
		RUE pain, L wrist CTA ± displacement, chronic (L) wrist/hand CT head - (R)
		A/P: s/p CHF, (R) great toe fx, subdural vs. epidural, scalp l-c, C7-T1 SPFx, L TP Fx
		(1) Neuro - CT head pending. Cont to follow. Cont C collar
		(2) CV - H+H stable. Cont to monitor. S/P 2U PRBCs
		(3) Resp - cont intubation/vent until head CT, other reassess.
		(4) Renal - good UOP, BUN+Cr. Cont IVF. Replace electrolytes
		(5) ID - Vanc/Claforan
		(6) MS - to ortho OR for washout in future. Cont RUE splint
		[signature] 15325

prgrecrd1 OTE 700222 Rev. 9/06

MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date of Surgery: 11/02/2007
Surgeon: Shane K. Woolf, MD
Assistant(s): Shaun L. Traub, MD
Yuehuei An, MD

PREOPERATIVE DIAGNOSIS: Crush injury to right foot with open fractures.

POSTOPERATIVE DIAGNOSIS: Crush injury to right foot with open fractures.

PROCEDURES:
1. Irrigation and debridement of open fracture of phalanges (skin to bone).
2. Closed reduction and percutaneous pinning of hallux second, third, and fifth toe proximal phalanx fractures (T5, T6, T7, T9).
3. Nailbed repair fourth and fifth toes (T8 and T9).

ESTIMATED BLOOD LOSS: Minimal.

INDICATIONS FOR PROCEDURE: This patient was crushed by a piece of construction equipment yesterday that fell on his head and foot. He sustained a closed-head injury with a cranial fracture, but was felt to be stable today for debridement of an open fracture about the right foot and management of the crush injury with multiple proximal phalanx fractures.

CONSENT: The risks and benefits were discussed with the patient's family including but not limited to bleeding, infection, nerve and vessel injury, wound healing complications, dysesthesia or paresthesia of the toes, malunion/nonunion of fractures, the need for reoperation, and possible amputation of one or all of the toes, as well as the risks of anesthesia. They understood and agreed to proceed.

DESCRIPTION OF PROCEDURE: Following consent and identification of the correct operative site, the patient was taken to the operating room and placed supine on the operating table. Prophylactic antibiotics were already administered prior to the operating room. He was maintained on the ventilator under general anesthesia. The limb was cleansed with chlorhexidine and prepared and draped in the sterile field with Betadine. The fourth and fifth toe as well as hallux nailbeds were debrided. There was a complex nailbed laceration to the fourth and fifth toes, which was debrided, irrigated, and repaired with 3-0 chromic interrupted stitches. There was also a small open wound over the lateral aspect of the foot overlying fractures to the fifth toe, proximal, and middle phalanges. This was irrigated also with saline after debridement. Fresh drapes were applied, then the minimally-displaced hallux distal phalanx fracture was stabilized with percutaneous pin which improved the overall clinical alignment. The second toe remained grossly unstable, and this was stabilized with a Kirchner wire. The image intensifier confirmed that the pin was contacting bone in multiple views. On the second toe where the wire went into the proximal segment to the proximal phalanx, there was only a portion of the cortex captured by the pin, but under direct visualization with the C-arm the fracture was satisfactorily stabilized, with plans to place him in a splint afterwards. Similar treatment was provided to the third ray. The fourth toe, which had a complex fracture and dislocation involving the proximal phalanx,

middle phalanx, and possibly a portion of the distal tuft of the terminal phalanx. Multiple attempts were made to reduce the fracture closed and percutaneously pin it. These were unsuccessful, so a 2 cm dorsolateral incision was made over the proximal interphalangeal joint, and a Freer elevator used to capture and stabilize the distal segment of the proximal phalanx. Crossed Kirchner wires were then passed through this fragment to provide some degree of stability to end of the small toe. Overall clinical alignment and stability were improved, but not idea. However, due to the comminuted nature of the fractures it was felt that more stable fixation could not be achieved. We were unable to pass a Kirchner wire in a retrograde fashion in the fifth toe due to extensive comminution. With the crosspin fixation there was satisfactory stability. A 1.6 mm wire was used in the great toe and second ray, and 1.25 mm in the third and fifth. All of the wounds were then irrigated again with saline. The nail plates from the fourth and fifth toes, which were removed and debrided, were reapplied loosely without suturing to protect the healing nailbed. Foot compartments were soft with no swelling noted before or after the procedure. Sterile dressings then were applied and he was placed in a well-padded posterior splint with stirrups.

He was then transferred to an ICU bed for transport to the intensive care unit in guarded condition. He tolerated the surgery without any apparent complications. All sponge and needle counts were reported as correct. I was present throughout the procedure.

Dictated by: Shane K. Woolf, MD

Shane K. Woolf, MD
Surgeon

918526 / 41737 /
JOB: 367907
DD: 11/02/07 04:24 PM
DT: 11/04/07 04:16 PM

Additional CC:_____

DOCID: 18231918526

Electronically signed by SHANE WOOLF, on 11-19-2007 at 10:21:56 AM

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5075490

MRN: 002581962
Date Exam Completed: 11/02/2007 08:10
Last Update: 11/03/2007

EXAMINATION: CT of the Brain 11/02/07 08:10:00

ACCESSION NUMBER: 5075490

INDICATION: s/p impact with heavy object, closed head injury.

COMPARISON: Head CT 11/1/07

TECHNIQUE: CT of the head without contrast

FINDINGS: There is no new hemorrhage nor clear signs of acute infarct. The CSF spaces are symmetric and unchanged. There is no herniation. Again seen is extensive left sided frontotemporal soft tissue swelling with gas, with underlying fracture is extends to the left frontal bone obliquely into the sagittal suture. The fracture posteriorly also extends into a lambdoid suture. The fracture line is again seen to extend obliquely through the roof of the orbit and traverses the posterior aspect of the optic canal. There has been interval increase in opacification of all the sinuses with gas fluid levels. The previously described extra axial fluid collection near the vertex is not as well seen on today's study; however does not appear any larger.

IMPRESSION:

1. No clear interval change, with no new hemorrhage, infarct, or herniation.

DICTATED BY: Dr. CHRISTOPHER MOSES
I have reviewed the images and agree with the findings in this report.

History: s/p impact with heavy object

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5075490

MRN: 002581962
Date Exam Completed: 11/02/2007 08:10
Last Update: 11/03/2007

Technologist: SHMICA HENDERSON
Interpreter 1: ZORAN RUMBOLDT
Interpreter 2: CHRISTOPHER MOSES
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: ZORAN RUMBOLDT
Date Authenticated: 11/3/2007

Transcribed by: Tech IntTalk

NRSRECRD

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GOMEZ, Hector

P:490943644 DOB:01/01/1951 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #

	0	1	2	3	4	5	S
PED	0	1	2	3	4	5	S
ADULT	0	2	4	6	8	10	SLEEPING
	NO HURTS	HURTS LITTLE BIT	HURTS LITTLE MORE	HURTS EVEN MORE	HURTS WHOLE LOT	HURTS WORSE	

1 2 3 4 5 6 7 8 9MM

DAILY WEIGHT 85.6K
TIME
LOSS/GAIN

TIME	TEMP	PULSE	SPON VENT RESP	CUFF BP	A-LINE BP	MAP PCWP	CVP	PA	CO CI	SVR	S.O2	ICP HI LOW	PAIN/SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL	EYES	
08	37.2	113	14/18		153/68						99										R DU NN
09	37.1	102	16/18	140/70	143/77	88					100										
10	37.1	95	18/18		135/76	95					100										
11	36.9	92	0/18		123/64	82					100										
12	36.9	91	0/18		114/64	81					100										
13	37.0	84	0/18		138/87	103					100										
14		82	0/18		140/80	83					100										
15																					
16																					
17	36.1	82	0/18	122/69	117/71	96					100										
18	36.9	83	0/18		141/92	111					100										
19	37.0	96	0/18		152/92	112					100										
20	37.9	100	—/18		160/86	106					100										
21	37.8	93	—/18		160/84	107					100										
22	37.1	92	1/18		165/92	113					100										
23	37.6	88	—/18	140/80	1	93					100										
24	37.4	88	2/18	148/81		96					100										
01	37.2	85	—/18	140/83		94					100										
02	37.1	84	—/18	133/82		93					100										
03	37.1	85	—/18	131/75		88					100										
04	37.0	86	—/18	140/78		89					100										
05	37.0	81	—/18	134/79		88					100										
06	37.3	110	15/—	149/70		89					97										
07	37.2	107	13/—	153/66		83					98										

@ CT
Bed/Bath A'd
MD @ BS - suture
↓ Placed
↓ Pleural Drain
RT
Pantoprazole
Sit on
Foley T-Sponge/Hem
Bath/Linen D
Labs
ABG

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials

UP# 411230 rev 8/03

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page 2 of 12

IV SOLUTIONS / ADDITIVES

Diprivan (10mg/mL) | 0.9%NS + 20KCl mEq | Fentanyl (50mcg/mL)

TIME													BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	PO	TUBE	INTAKE TOTALS HRLY TOTAL	CUM TOTAL
08	7.9 20	125 325	1									33		NPO	0	0	139	139
09	7.9 20	125 250	1 2									36			0	0	139	278
10	7.9 20	125 375	1 3									39			0	0	139	417
11	22 52	125 975	1 4									312			0	0	124	541
12	22 74	125 600	1 5									315			0	0	124	665
13	9.9 54	125 625	1 6									318			0	0	139	804
14	10 54	125 750	1 7									321			0	0	139	943
15												324			0	0		
16												327			0	0		
17	CK		1 8									330			0	0	4	948
18	12 106	125 725	1 9									333			0	0	141	1089
19	12.2 118	125 850	1 10									336			0	0	566	1655
20	12.2 150	125 1050	1.5 11									51					142	1797
21	12 142	125 975	1.5 13									42					142	1939
22	20 162	125 1200	1.5 14									45					142	2081
23	20 182	125 1425	1.5 16									48					142	2223
24	20 202	125 1650	1.5 18									51					142	2365
01	20 222	125 1875	1.5 20									54					142	2507
02	20 242	125 2100	1.5 22									57					142	2649
03	20 262	125 2325	1.5 24									60					142	2791
04	20 282	125 2550	1.5 26									63					142	2933
05	9 291	125 2775	1.5 28									66					137	3075
06	9 300	125 2775	1.5 30									69					514	3589
07	12 312	125 1400	1.5 32									72					142	3731

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

07W - pt moaning, repeats name & c/o pain. MD @ BS & D/P WNL. Pt localizes to pain x 4 ext & appears to squeeze BIL hands when asked. PERL 4mm. NPO. NGT LCWS. Pt BIC. Foley CKU @ 5. See full assess. KH 0800 - pt to CT & LTC etc. KH 0840 pt back from CT. Head 1 Back dsg CDI. Mitts & pad D/C KH 0905. ABG sent. KH 0945 - Mag 4. await CSI. KH 10W - MD @ BS to remove sutures & wash out lac on head. KH 1050 MD to still suturing head. D/C pt finished & D/P man notified from CT. KH 1150 - MD to still suturing head lac. pt to still sedated. KH 12W MD done. ABG KH 12W & D/P man at KH 13W - o/family here. MD called from pt for CT to repeat. KH 14W - to MICU RN & RT. KH 1650 - Pt return from CT. KH D/C assess = sedated / paralyzed & pupils equal & reactive to all. D/C foley & bed bath, dsg CDI from all PICC made. KH 17W - MD @ BS - BS clear KH 18W - still sedated - no movement yet. KH 18W pt awake. Maintained on BIL VE & WE. 6 FC yet. Will monitor. KH 19W - will report off. KH (19TO) RW to RW report. 12° chart √. (92) (2000) Assessment complete. Briskly localizes BUE, RLE. Eyes open to voice. BBS CTA. Abdomen soft, non distended, hyperactive bowel sounds. (R) foot splint & toes pinked. Cap refill WNL. Temp warm. VSS. Alarms on. GTTs verified. (92) (2100) Bath. Linen & A-line D/C'd 2° to poor wave/no blood return. VSS. (92) (0400) Undanged. (92) (0300) Labs. (92) (0500) CPAP. (92) (0700) RW to RW report. 12° chart √. (92)

UP# 411230 rev 8/03

NRSRECRD

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

NOV 02 2007

P:490943644 DOB:01/01/1851 L M
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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	FC	STOOL	EMESIS	OGT/G	RESID			
08	125	125	125			+				
09	225	200	225							
10	450	225	450							
11	575	125	575							
12	725	150	725							
13	875	150	875							
14	1100	225	1100							
15			FC							
16										
17	1325	225	1325							
18	1575	250	1575							
19	1800	225	1800			+/-		+		
20	2050	250	2050							
21	2180	130	2180							
22	2380	200	2380							
23	2480	100	2480							
24	2600	120	2600							
01	2725	125	2725							
02	2850	125	2850							
03	2900	150	2900							
04	3050	150	3050							
05	3200	150	3200							
06	3875	675	3525			500/50				
07	4175	300	3825							

UP# 411230 rev 8/03

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TRAUMA
VICTIM JW
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007

SAFETY

- ☑ Hospital ID band on
- ☑ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position
- ☑ Bed brakes on
- ☑ Bed alarms on
- ☑ Bed heel pressure relief
- ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ Violent behavior
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other _____
- ○ Any risk criteria identified, implement the **Safety** section of the **POC.**

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose debate	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls In past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below
SUBTOTAL:	2	2	3	3
TOTAL POINTS:	5	☐ N/A Patient < 6 years old		

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

If score ≥ 6, implement **Safety** section of the **POC.**

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE	/				
A-LINE SITE CARE					
TRACH CARE	/				
BATH	9 AM KH				
FOLEY / PERI CARE	9 KH				
FOLEY D/C'd	/				
STRAIGHT CATH	/				
LINEN CHANGE	9 KH				
SKIN CARE	9 KH				
PEG SITE CARE	/				
TYPE OF DIET	NPO 9 KH				
% EATEN	/				
PACING WIRES INSULATED SECURED	/				
SPECIALTY BED	9 KH				
Miami A PAD 9	9 KH				

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NRSRECRD

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007

page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES			HEMATOLOGY				CHEMISTRY							
TYPE O2 DEL	MODE RATE	FiO2 TV	PEEP PS	CPAP PIP	MIN VENT		AAV PH	PO2 PCO2	HCO3 O2SAT	HCT HGB	WBC RBC	PT PTT	PLT INR	NA K	CL CO2	GLUC BUN	CREAT CA	MG PHOS		FSBS	
V	18	50 / 550	8			1CA	A 7.31	126 / 46	22.5 / 94.9					3.9							08
																					09
																					10
																					11
						1.29 / 1.29								141 / 3.7	112 / 25	114 / 8	.9 / 8.9	2.0	2.3		12
																					13
																					14
																					15
																					16
																					17
							A 7.32	114 / 44	21.5 / 98.1	24.1 / 8.9	8.8 / 5.02		97	136 / 3.7	109 / 22	62 / 5	1 / 81	2 / 2.5			18
																					19
V	PRVC 16	.50 / 550	5																	NH	20
																					21
																					22
																					23
																				157	24
																					01
																					02
							A 7.36	109 / 39	21.3 / 97.9	24.4 / 8.1	7	5	142 / 24.6	138 / 3.5	109 / 23	110 / 4.9	1.0 / 8.3	2.1 / 2.1			03
													88 / 1.35							110	04
	CPAP		5																		05
			5 / 15																		06
			5 / 10																		07

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page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/1/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(L) RAD	DI	0730	(+) BLOOD FLOW
P	S	(L) rad	DI	730	

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: PIV #16 g Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	(L) HAND	S	DI	(+)
P	(L) hand	S	DI	(+)

Line #2 Type: IV #14 g Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	(L) AC	S	DI	(+)
P	(L) AC	S	DI	(+)

Line #3 Type: PIV #16 Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	(R) FA	S	DI	(+)
P	(R) FA	S	DI	(+)

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

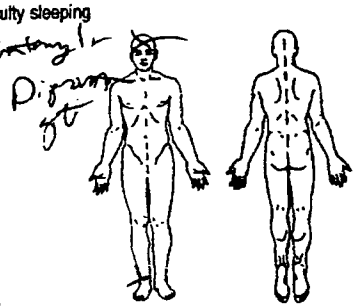
Abnormal Findings

☐A☐P Nausea ☐A☐P Itching ☐A☐P Chills
☐A☐P Fever ☐A☐P Sweating ☐A☐P Difficulty sleeping
☐A☐P Pain ☐A☐P Receiving analgesic therapy
(A) Pain Score: NONE Patient Goal: 02/10
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A☐P New ☑A☐P Ongoing

Pain Description
☐A☐P Dull ☐A☐P Constant
☐A☐P Burning ☐A☐P Cramping
☐A☐P Stabbing ☐A☐P Radiating
☐A☐P Throbbing ☐A☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



If any problems identified, implement **Comfort** section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

☑ **Psychosocial / Spiritual / Education** A_____ P_____
☑ **Comfort** A_____ P_____
☑ **Neurologic / EENT** A_____ P_____
☐ **Safety** A_____ P_____
☐ **Functional / Musculoskeletal** A_____ P_____
☑ **Skin / Wound** A_____ P_____
☑ **Cardiovascular** A_____ P_____
☑ **Respiratory** A_____ P_____
☑ **Gastrointestinal** A_____ P_____
☐ **Genitourinary** A_____ P_____
☐ **Nutrition** A_____ P_____
☐ **Discharge Planning** A_____ P_____
☐ **Other** _____ A_____ P_____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE _____ TIME 0730

PM SHIFT ASSESSMENT
SIGNATURE _____ TIME 2000

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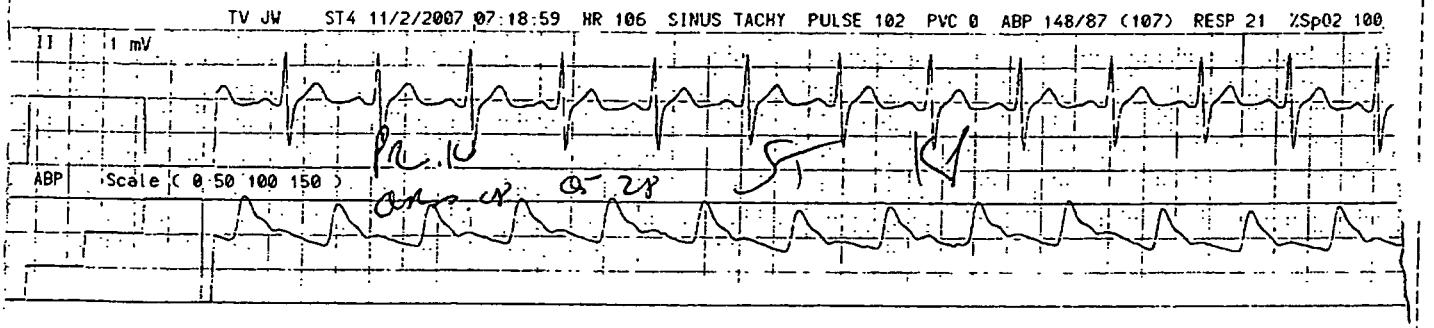
NRSRECRD

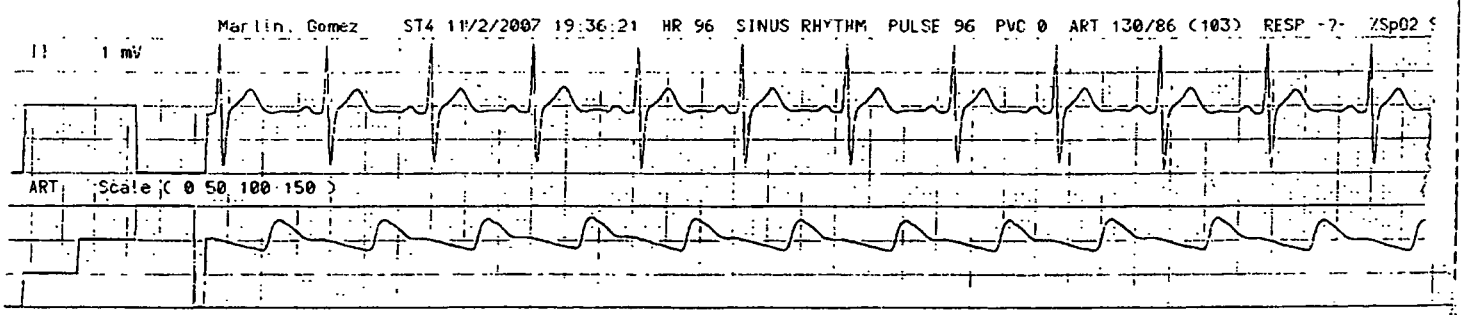
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THIS SPACE MONITOR STRIPS





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page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm)
☐ A ☐ P Hernia, site

Bowel habits
☐ A ☐ P *Incontinent*
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location A	✓ / location P	Suction A	Suction P	Drainage A	Drainage P
NGT						
OGT	✓	✓	LC	LC		
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

☐ Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A P

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
☐ Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ *Document any variations from normal limits in progress notes.*

Postpartum Delivery date
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm A	R Arm P	L Arm A	L Arm P	R Leg A	R Leg P	L Leg A	L Leg P
Limited ROM								
Weakness								
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location

Devices Site / Type
☐ A ☐ P SCD/boot pump
☐ A ☐ P TED
☐ A ☐ P Traction
☐ A ☐ P Cast/splint
☐ A ☐ P External fixator
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ☐ A ☐ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P *Difficulty swallowing*
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin Impairments

Location
☐ A ☐ P Surgical incision
dressing type/appearance
☐ A ☐ P Drain
☐ A ☐ P Drain
☐ A ☐ P Wound
dressing type/appearance
☐ A ☐ P Other
☐ A ☐ P Other

Wound vac™

	Location	mmHg	Suction
A			
P			

☐ Any problems identified implement **Skin/Wound** section of the **POC.**

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location Head
☒ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☒ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☒ Bloody ☐ Odor
Surrounding skin
☒ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change QD Time
Dressing type Elastic 0830

Surgical Incision #2 Location RL Arm
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change Post of Cont / Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	8	10	12	14	16	18						
Suction/cough / Secretions	S TN	S TN	S TN	S TN	OR	S TN						
HOB>30 degrees unless contraindicated	✓	✓	✓	—		—						
A line site ✓	✓	—	—	—		✓						
IV site ✓	✓	—	—	—		✓						
Chest tube patent ✓	NA	→	→	→		NA						
NG/OG place ✓	✓	—	—	—		✓						
Mouth care	✓	—	—	—		✓						
Turn / Passive ROM	✓	—	—	—		—						
Side Rails	A x2	→	→	→		✓						
Incen. Spir./ deep breathe	VENT	→	→	→		✓						
Alarms on / Assessment reviewed	✓ KP	— KP	— KP	— KP		✓ KP						

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NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.
☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.
☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.
☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.
☐ A ☐ P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	2	2	2	2
P	2	2	2	2

Reflexes Absent
☐ A ☐ P Cough ☐ A ☐ P Gag
☐ A ☐ P Corneal

Drainage
☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea
☐ A ☐ P Eye
1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices
☐ A ☐ P Cervical collar Miami J
☐ A ☐ P Cervical traction
☐ A ☐ P Halo
☐ A ☐ P Tongs
☐ A ☐ P Shunt: _____
☐ A ☐ P Codman reference # _____
☐ A ☐ P Other _____

Impairments
☐ A ☐ P Hearing
☐ A ☐ P Eyes
☐ A ☐ P Unable to assess

Fontanel
☐ A ☐ P Full ☐ A ☐ P Bulging
☐ A ☐ P Sunken

Emotional status
☐ A ☐ P Inconsolable

☐ Any problems identified, implement **Neurologic / EENT** section of the **POC**.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart
☐ A ☐ P Arrhythmia SR-ST
☐ A ☐ P Click
☐ A ☐ P S3
☐ A ☐ P Distant heart sounds
☐ A ☐ P S4
☐ A ☐ P Rub
☐ A ☐ P Capillary refill > 3 sec.

Murmur
☐ A ☐ P Faint
☐ A ☐ P Moderate
☐ A ☐ P Loud
☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A	WNL				
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	2	1	2	1	facial
P	1		1		face/head

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	2		2		
P	2	2	2	2	

Pacemaker / wires
☐ A ☐ P Permanent ☐ A ☐ P Transvenous
☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial
Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter
☐ A ☐ P AICD

☐ Any problems identified, implement **Cardiovascular** section of the **POC**.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.
☐ A ☐ P: Suction functioning
☐ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations
☐ A ☐ P Labored ☐ A ☐ P Shallow
☐ A ☐ P Irregular ☐ A ☐ P Orthopnea
☐ A ☐ P Stridor ☐ A ☐ P Pleural rub
☐ A ☐ P Accessory muscle use
☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation
☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	C	C	D	C	
P	C				

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngoectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ET	8.5		24cm
P	ET	8.5		24cm

☐ A ☐ P Emergency trach supply box
☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage
S=serous; SS=serosanguinous; B=bloody; P=purulent
Air leak / SQ emphysema
P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☐ Any problems identified, implement **Respiratory** section of the **POC**.

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PRGRECRD

Adult Nutrition Progress Note
Assessment for Nutrition Support
Page 1 of 1

Form Origination Date: 9/04
Version: 3 Version Date: 4/05

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TRAUMA
VICTIM JW
Adm:00000000 M2581962
Patient Name
MRN
STAMP PLATE AREA

Service / Attending: CC | Minshall Reason for Evaluation: Intubated | ICU.

Report of Consultation:

Ht: 64" (estim) in Wt: 89.6 kg IBW: 59.1 kg BMI: 33.9 kg/m² UBW: ____ kg % UBW: ____ Adjusted BW: 66.7 kg

Estimated Requirements: 1465-1870 total kcal / day (25-28 kcal / kg / day)
95-105 gm protein / day (1.4-1.6 gm protein / kg / day)
____ mL water / day (____ mL /kg / day)

Diet Order / Nutrition Support: NPO

History / Nutrition Assessment:
?40 HM admitted yesterday s/p inj c crani
pt intubated, OGT in place.

Objective Indicators of Malnutrition
- ☐ Prealbumin <10 mg/dL &/or transferrin < 100 mg/dL
- ☐ > 10% weight loss over 2-3 month period
- ☐ < 85% of usual body weight (UBW)
- ☐ BMI < 17

Pertinent Laboratory Data:

11/2 | 144 | 113 | 9 | 102
2.9 | 25 | 1.1

7.8 / 1.5 / 3.2 K replaced = 3.9 WBC 4.84

Pertinent Medications / Vitamins / Herbals / Supplements:
propofol cont (9.9 mL/hr) pepcid
NS c 20KCl @ 125 mL/hr.

Goals: ① NPO < 3 days
② optimize nutritional status

Assessment / Plan: ① Monitor labs, wt, I/Os
② If prolonged intubation expected -
- TF while pt on propofol @ current rate: promote @ 60 mL/hr c 1 pkt prostat. Provides 1500 kcals (+261 from propofol) = 1761 (26 kcal/kg) + 105 g pro (1.6 g pro/kg).
- If propofol off - TF as below.

③ F/u + adjust TF's pm.

☒ Enteral Nutrition: Access: NGT
Formula: promote Goal Rate: 70 Flush: 50 mL q 6°
Provides: Energy: 1680 kcal / day 25 kcal / kg / day 218 gm CHO / day
Protein: 105 gm / day 1.6 gm protein / kg / day 1611 mL free water

☐ Parenteral Nutrition: Access: ____
Provides: Energy: ____ kcal / day ____ kcal / kg / day ____ gm lipid / day ____ gm CHO / day
Protein: ____ gm / day ____ gm protein / kg / day Rate: 1 mL /hr

Signature James J Bennett MD ANSP Pager ID 1-2733 Date 11/2/07 Time 10:00 AM/PM
Co-Signature (if applicable) ____ Pager ID ____ Date ____ Time ____ AM/PM

adultnutprog OTE 900196 Rev. 4/05

"PRGRECRD"

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3 Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
12/11/07	02:30	NSVRS 0 acute events V - 109 18 123/85 100% on vent O/E - sedated intubated CVS RRR Resp - b/l chest rise CNS - EM VBT MS PERRL. bowel sounds b/l UE, no withdraws b/l LE A&P - CHF c O2 F-P should go c pacing c CVP, spo2 stable, cont. c current plan, cont to follow [illegible] 1538

prgrecrd1 OTE 700222 Rev. 9/06

"PRGRECRD"

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P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

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USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
6/2		Ortho S: intubated O: (R) UE: splint C/D/I toes warm cap refill <2 sec - small open lacerations over 4th & 5th Distal phalanx - (R) UE in splint A/P: (R) 1-5 phalanx fx, 4 & 5 grade I open (R) Ulnar fx 1) cont. Ancef 2) Sling (R) UE 3) we will discuss if operative intervention is indicated M Z 15228
11/2/7		Ortho - Staff Intubated, Sedated, Localized 37.2 95 139/76 95% PRVC (R) shoulder @ swelling, skin intact (R) UE in splint, Toes perfused, CR ~ 2-3 sec. Complex. Lac 5th toe > dry blood- Small lac - great Toe Xrays → Fx's of great → 5th toe phalanges. (R) clavicle (midshaft) fx.

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/08

P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
		A/P (1) CHI ± cranial Fx (2) (R) closed clavicle shaft Fx (3) (R) I open foot Fx's. – Had promised I+D of small open and (R) foot in ED on admission. – will cont IV abx + splint for now. – Plan to I+D formally ± CRPP Toe Fx's when neurologically & HD stable. – CCU team aware of plan & will notify us when he is safe to proceed.
11/1/07		Attending - Trauma Lacerations Alert & oriented x 3, pleasant, cooperative

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OTE 700222 Rev. 9/08

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
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Patient Name _____
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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not .5 mg

Date	Time	
11/2/07	6PM	ortho postop intubated, stable 36^9 83 141/90 & 10% /525 VOP sedated, paralyzed RE splint intact, TRC adequately perfused, good color, cap refill <2s cannot assess movement, neuro exam 2E not tense, all dressings clean-dry A/P - s/p IGD, CRPP, Nailed Repair T8, T9 - will obtain better neuro exam when responsive, non-paralyzed - cont Abx - wee follow Craig Colton ISMAS
11/3/07	01:35	NSURG ϕ acute events V - 37^9 85, 18, 143/83, 100% on PR VC, 18, 40%, 550, 5 O/E sedated, intubated CV3 - RRR 2507/2251 Resp - b/l chest rise Abd - soft CNS - E2 V[illegible] M5 briskly tracking b/l UE, WD b/l LE Pupils b/l small NR A/P: HI c CT FP skull fx - open, GCS - SFx stable. Cont. c current plan Cont to follow. Dr. [illegible]

prgrecrd1

OTE 780222 Rev. 9/06

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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5076745

MRN: 002581962
Date Exam Completed: 11/03/2007 13:27
Last Update: 11/04/2007

EXAMINATION: CHEST 11/03/07 13:27:00

ACCESSION NUMBER: 5076745

INDICATION: 27 yo male s/p CHI, extubated today and emergently reintubated

COMPARISON: 11/01/07.

FINDINGS: Single frontal radiograph of the chest demonstrates stable size and contour of the cardiomedistinal silhouette. Endotracheal tube has been advanced and its distal tip is 1 cm from the carina. Again noted are bilateral apical air space opacities, likely pulmonary contusions. There has been interval development of left lower lobe opacity. There is evidence of pneumothorax. Nasogastric catheter and temperature probe are unchanged. Bones structures are unchanged; right clavicular fracture is again noted.

IMPRESSION:

1. Interval advancement of endotracheal tube

2. Interval development of left lower lobe opacity. Air space disease versus pleural effusion with subsegmental atelectasis.

3. Persistent apical airspace opacities, likely pulmonary contusions

VOICE DICTATED BY: Dr. Dobrinka Dimitrova
I have reviewed the images and agree with the findings in this report.

History: 27 yo male s/p CHI, extubated today and emergently reintubated

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5076745

MRN: 002581962
Date Exam Completed: 11/03/2007 13:27
Last Update: 11/04/2007

Technologist: JOHN WILLIAMSON
Interpreter 1: TIMOTHY ALDER
Interpreter 2: DOBRINKA DIMITROVA
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: TIMOTHY ALDER
Date Authenticated: 11/4/2007

* N R S R E C R D *

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NOV 03 2007

P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

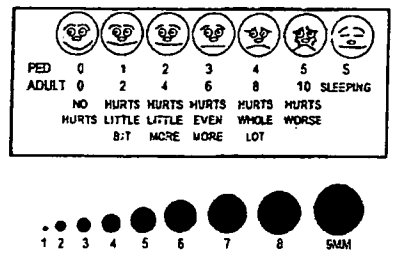
VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # _____



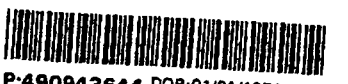
TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN / SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL
08	37.2	113	18 /	147/83		96					98									
09	37.1	120	18 /	134/88		100					99									
10	37.0	152	22 /	168/90		104					100									
11	38.4	129	1 / 18	150/89		100					100									
12	37.8	117	0 / 18	TO	160/	104					100									
13	37.1	120	1 / 18		150/82	102					100									
14	38.1	133	1 / 18		151/83	103					100									
15	38.3	120	1 / 18		143/80	98					100									
16	37.9	108	0 / 18		146/80	101					100									
17	38.2	116	0 / 18		122/80	88					100									
18	37.4	116	0 / 18		168/58	116					100									
19	37.3	114	0 / 18		150/88	107					100									
20	37.6	103	0 / 18		158/98	112					100									
21	37.4	95	1 / 18		160/87	108					100									
22	37.8	93	— / 18		161/89	112					100									
23	37.7	94	— / 18		170/92	114					100									
24	37.8	97	— / 18		163/86	109					100									
01	37.4	91	— / 18		159/84	106					100									
02	37.1	91	— / 18		134/72	98					100		Bath, Linen ○							
03	37.2	90	— / 18		154/86	105					100		Labs							
04	36.9	87	— / 18		147/71	100					100									
05	37.1	84	— / 18		152/79	102					100									
06	36.9	82	— / 18		149/78	100					100									
07	36.9	83	— / 18		149/74	95					100									

* - opioid agonist

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P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
		7p-7a	

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page 2 of 12

(STAMP PLATE)

P:490943644 DOB:01/01/1851 L M
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SOLUTIONS / ADDITIVES

TIME	Diprivan	Fentanyl	0.5 NS + 20 KCL	Insulin gtt (Hallway)	A-line	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	PO	TUBE	INTAKE TOTALS HRLY TOTAL	CUM TOTAL
08	5.9 10	1.5 2	125 125				NPO	0	0	137	137
09	4.6 15	1 3	125 250					0	0	131	268
10	X	X	125 375					0	0	125	393
11	23.1 38	X	125 500					0	0	148	541
12	22.1 61	X	125 625					0	0	148	689
13	23.1 84	X	125 750					0	0	148	837
14	23.1 107	X	125 875					0	0	148	985
15	23.1 130	X	125 1000					0	0	148	1133
16	23.1 153	X	125 1125					0	0	148	1281
17	23.1 176	.5 .5	125 1250					0	0	149	1430
18	23.1 199	1 1.5	125 1375					0	0	150	1580
19	23.1 222	1 2	125 1500					0	0	150	1730
20	23 245	1 3	125 1625	2.5 3	3 3					153	1883
21	23 268	2 5	125 1750	1.4 4	3 6					154	2039
22	23 291	2 7	125 1875	1.3 5	3 9					154	2193
23	23 314	2 9	125 2000	1.3 6	3 12					154	2347
24	23 337	2 11	125 2125	1.3 7	3 15					154	2501
01	23 360	2 13	125 2250	2 9	3 18					155	2656
02	23 383	2 15	125 2375	3 12	3 21					156	2812
03	23 406	2 17	125 2500	1.4 13	3 24					154	2966
04	19 325	2 19	125 2625	1.4 14	3 27					150	3116
05	19 344	2 21	125 2750	1.7 15	3 30					150	3266
06	18 360	2 23	125 2875	2.1 17	3 33					148	3414
07	14 500	2 25	500 3375	6.1 23	3 36					525	3939

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page 11 of 12

PROGRESS NOTES

Time — Record changes in patient's status and patient/family education

0730 - pt alert & oriented x 3. chart r/v. assessment performed per flow sheet @ all. Vitals. to pain well-related to pt's pain 3 on 1-10 scale. Foley, @ 30 mL/hr. CHG. MD's Foley cycle. will monitor. Pt. K+ 0810 - cc @ bedside. PCA d/c'd, dc'd to pt & awake. agitated & pain - treated. Pt's family @ bedside & pt to awake. agitated & pain - treated. Pt's family @ bedside & pt to awake. agitated & pain - treated. Pt's family @ bedside & pt to

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STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS							BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	FC	STOOL	EMESIS	OG/NG	RESID									
08	350	350	350			(0)		Flare								
09	650	300	300			(+)		Dark								
10	875	225	225			/		(+)								
11	1300	425	425 1300			(+)										Foley d/c'd - IT. pulled Replaced
12	1800	500	500 1800													
13	2400	600	600 2400													
14	2600	200	200 2600													
15	2900	300	300 2900													
16	3200	300	300 3200													
17	3550	350	350 3550													
18	3825	275	275 3825													
19	4125	300	300 4125			(+)		(+)								
20	4725	600	600 4725													
21	5115	390	390 5115													
22	5365	250	250 5365													
23	5380	15	15 5380													
24	5700	320	320 5700													
01	5850	150	150 5850													
02	6025	175	175 6025													
03	6295	270	270 6295													
04	6420	125	125 6420													
05	6545	125	125 6545													
06	6670	125	125 6670													
07	7470	800	400 7070			400 400										

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NOV 03 2007

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page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☑ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position
- ☑ Bed brakes on
- ☑ Bed alarms on
- ☑ Bed heel pressure relief
- ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ Violent behavior
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other _____
- ○ Any risk criteria identified, implement the **Safety** section of the **POC.**

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose Sedated	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:	5	2	0	3
TOTAL POINTS:	5	☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement **Safety** section of the **POC.**

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION		FA LUA		
IV SITE CARE LOCATION				
IV TUBING CHANGE	10 KV	02		
PICC LIMB CIRCUMFERENCE				
A-LINE SITE CARE				
TRACH CARE				
BATH	1050 KV	02		
FOLEY / PERI CARE	8 KV	23 02		
FOLEY D/C'd				
STRAIGHT CATH				
LINEN CHANGE	1050 KV	02		
SKIN CARE	8 KV	02		
PEG SITE CARE				
TYPE OF DIET	NPO 8			
% EATEN				
PACING WIRES INSULATED SECURED				
SPECIALTY BED	8 KV			
Miami J Collar	10 KV	02		

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 3 2007

page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES				HEMATOLOGY				CHEMISTRY								
TYPE O_2 DEL	MODE / RATE	FIO_2 / TV	PEEP / PS	CPAP / PIP	MIN VENT		AV / PH	PO_2 / PCO_2	HCO_3 / O_2SAT		HCT / HGB	WBC / RBC	PT / PTT	PLT / INR	NA / K	CL / CO_2	GLUC / BUN	CREA / CA	MG / PHOS		FSBS	
V	CMV	40	5																		151	08
			10																			09
V	PRVC	60	5																			10
	18	550																				11
							A	163	22.2												188	12
		45					7.37	92	98.6													13
																						14
																						15
																					118	16
																						17
																						18
																						19
V	PRVC	.40	5																		113	20
	19	550																			108	21
																					105	22
																					104	23
																					111	24
																					119	01
																					98	02
							A	152	23.1	25.4	6.0	11.0	110	139	112	90	0.8	2.2			95	03
							7.39	89	98.4	8.6	3	34.0	1.08	(3.4)	24	4.0	5.3	(1.9)			94	04
																					130	05
																					213	06
																						07

UP# 411230 rev 8/03

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NOV 03 2007

P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962
PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time
A				
P				

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing
A			
P			

Line #1 Type: PIV 16 Insert Date: 10/ /07

	Site	Appearance	Dressing	Blood Return
A	RFA	S	D/I	+
P	LHand	S	D/I	+

Line #2 Type: PIV 14 Insert Date: 10/ /07

	Site	Appearance	Dressing	Blood Return
A	RAC	S	D/I	+
P	LAC	S	D/I	+

Line #3 Type: PIV 16 Insert Date: 10/ /07

	Site	Appearance	Dressing	Blood Return
A	RFA	S	D/I	+
P	LFA	S	D/I	+

Line #4 Type: _____ Insert Date: / /

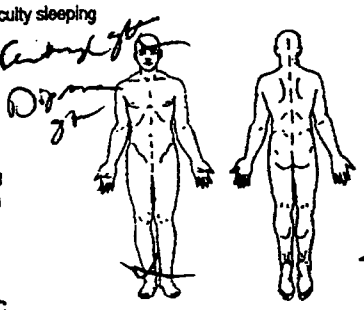
	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy
(A) Pain Score: N/A Patient Goal: 0-2 to
(P) Pain Score: _____ Patient Goal: _____
Pain Onset ☐A ☐P New ☐A ☐P Ongoing
Pain Description ☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling



Location of pain (on the diagram, put an X on the area where the patient complains of pain)
If any problems identified, implement **Comfort** section of the **POC.**

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

- ☐ Psychosocial / Spiritual / Education A____ P AA
- ☐ Comfort A____ P M
- ☐ Neurologic / EENT A AA P AA
- ☑ Safety A AA P M
- ☐ Functional / Musculoskeletal A M P M
- ☐ Skin / Wound A M P M
- ☐ Cardiovascular A M P M
- ☐ Respiratory A M P M
- ☐ Gastrointestinal A M P M
- ☐ Genitourinary A____ P M
- ☐ Nutrition A____ P M
- ☐ Discharge Planning A____ P____
- ☐ Other _____ A____ P____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE TIME 0700

PM SHIFT ASSESSMENT
SIGNATURE TIME 2000

UP# 411230 rev 8/03

NRSRECRD

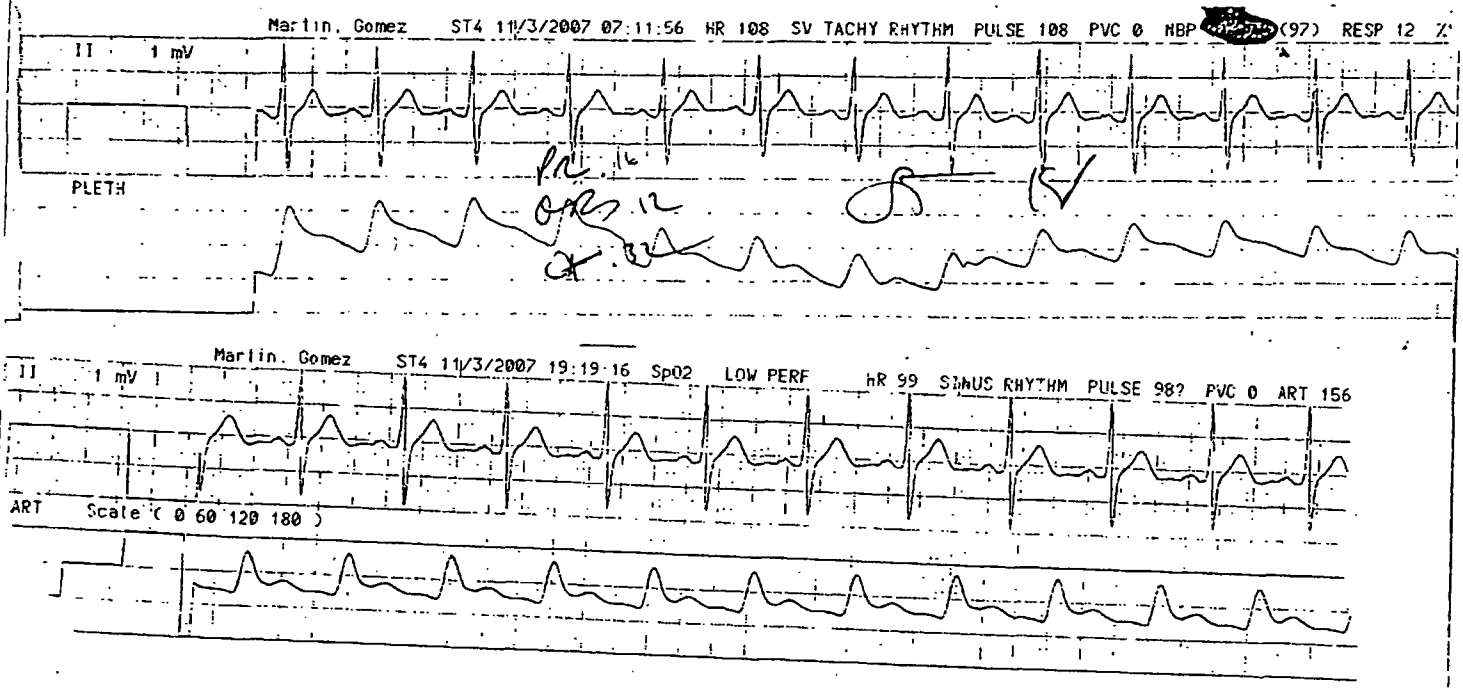
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 03 2007

page 5 of 12

P:490943644 DOB:01/01/1851 L M
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THIS SPACE MONITOR STRIPS



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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 03 2007

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm)
☐ A ☐ P Hernia, site

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT	✓	✓	LI	CG	G	CL
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

☐ Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A P

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
☐ Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness								
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location

Devices Site / Type
☐ A ☐ P SCD/foot pump
☐ A ☐ P TED Cath
☐ A ☐ P Traction
☐ A ☐ P Cast/splint
☐ A ☐ P External fixator
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ☐ A ☐ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin Impairments

Location
☐ A ☐ P Surgical incision
dressing type/appearance
☐ A ☐ P Drain
☐ A ☐ P Drain
☐ A ☐ P Wound
dressing type/appearance
☐ A ☐ P Other
☐ A ☐ P Other

Wound vac™

	Location	mmHg	Suction
A			
P			

☐ Any problems identified implement **Skin/Wound** section of the **POC.**

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HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 03 2007

page 6 of 12

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location L leg
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other
Dressing change CDS Pt up Time
Dressing type

Surgical Incision #2 Location L heel
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other
Dressing change OTA Time
Dressing type cleaned c&w

Wound #1 Location
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length ____ cm
Width ____ cm
Depth ____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined ____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other
Dressing change ____ Time
Dressing type

Wound #2 Location
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length ____ cm
Width ____ cm
Depth ____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined ____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other
Dressing change ____ Time
Dressing type

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	8	10	12	14	16	18	20	22	24	02	04	06
Suction/cough Secretions	S Tan	C Th	O Th-Bl	O Tan	O Th-T	O Tan	S Th Y	S Th, Y	S Th, Y	S Scant	S Scant	S Scant
HOB>30 degrees unless contraindicated	✓	✓	Th —	—	—	—	✓	✓	✓	✓	✓	✓
A line site ✓	NA	→	→	→	→	→	✓	✓	✓	—	—	—
IV site ✓	/	/	/	/	/	/	✓	✓	✓	✓	✓	✓
Chest tube patent ✓	NA	—	—	—	→		NA	—	—	—	—	—
NG/OG place ✓	✓	Dc	D	→	→		✓		✓		✓	
Mouth care	—	—	—	—	—	—	✓	✓		✓	✓	✓
Turn Passive ROM	✓	/	/	/	/	/	✓	✓	✓	✓	✓	✓
Side Rails	4 x L	→	→	→	→	→	x2	—	—	—	—	—
Incen. Spir./ deep breathe	Vent	PR	VW	→	→	→	vent	—	—	—	—	—
Alarms on Assessment reviewed	✓ KC	KC	KC	KC	KC	KC	✓	✓	✓	✓	✓	✓

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR M:2581962
Adm:11/01/07 (PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 3 2007

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☐ A ☐ P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	2	2	1	2
P	2	2	1	2

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☐ A ☐ P Cervical collar _____

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☐ A ☐ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐ A ☐ P Arrhythmia ST 110-120

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A	WNL				
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	Generalized
A	1	1	1	1	face
P	1	1	1	1	1

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	2	+D	2	2	
P		+D			

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☐ A ☐ P: Suction functioning

☐ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	CTA			CTA	
P	R	R	R	R	R

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	placement @ lip
A	OTT	8.5	—	24 c
P	ET	7.5		22

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

Any problems identified, implement **Respiratory** section of the POC.

CONSULT

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PHYSICIAN CONSULTATION REPORT
Page 1 of 1

P490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M2581962

Written order in medical record ☐ Yes ☑ No Physician/Service notified by: STICH Date: 11/5/07
Requested by: Dr. Hallett Pager: 14636 Service being consulted: anesthesia
Attending Name
CC/Reason for Request: Intubation

HPI: Intubation for airway protection

Allergies:
Medications:
PMH:
FH: SH:
ROS: ☐ All Others Negative

Exam:

Assessment/Plan: RSI c propofol 200mg & succinylcholine 100mg. ⊕Cricoid pressure. In-line stabilization of C-spine. Grade I view. cMAC4, #8.0 ETT. ⊕ETCO2, BBS= ETT secured 22cm @ lips by resp. therapy

Consult reviewed with and patient examined by Dr: _____. See Page 1 Addendum for attending note.

Resident's Signature	Pager ID	Date of consult	Time
Brad Hallett	14636	11/5/07	0357AM
Attending Physician Signature	Pager ID	Date of consult	Time

OTE 801015 Rev. 4/04

SPENDO

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Arterial Line Procedure Note: Critical Care Services

Page 1 of 1

Form Origination Date: 10/02
Version: 3 Version Date: 2/07

P490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M2581962

Patient Name _____
MRN _____
STAMP PLATE AREA

Patient Safety: ☒ Correct patient ☒ Correct procedure
☒ Time Out observed ☐ Fall precautions

Using sterile technique, a 20 gauge catheter was introduced into the R radial artery. An Allen test ☒ was ☐ was not (check one) performed prior to insertion. 1% lidocaine local anesthesia ☒ was ☐ was not (check one) used during insertion. Following the procedure, a sterile dressing was applied and the catheter was attached to a pressure transducer for monitoring purposes. The indication(s) for insertion was (were):

☒ Need for frequent blood draws (> 4 times/day)

☐ Hemodynamic instability requiring vasoactive agent support

☐ Hypertension requiring continuous intravenous vasodilator therapy

☐ Profound obesity preventing accurate assessment of blood pressure by non-invasive means

☐ Monitoring of cerebral perfusion pressure

☐ Other: _____

There ☐ were ☒ were no (check one) apparent complications of procedure.
Additional comments:
Good waveform and blood return noted.

Signature of Physician/Therapist performing procedure:

[signature] RT, MD (circle one) Pager ID 18052 Date 11/3/07 Time 1105 AM/PM

My signature below certifies that I ☐ was ☐ was not (check one) present and personally supervising the entire procedure. (Lack of signature does not imply lack of proper supervision. This relates only to attending physician presence for the entire procedure as defined under the CMS regulations for supervision by teaching physicians.)

I certify that this person ☐ is ☐ is not (check one) qualified to perform this procedure unsupervised.

Attending Physician Signature _____ Pager ID _____ Date _____ Time _____ AM/PM

ICUARTERIAL OTE 900358 Rev. 2/07

MUSC
171 Ashley Ave. Cl ton, SC 29425
Name: , `
MRN: _____ Acct #: _____ Age: _____ Sex: M F
Temp: _____ Pulse: 116 BP: 141/79 RR: [illegible] Pulse Ox: _____ Wt: _____
Provider: _____ Prov #: _____ Time Seen: _____
Chief Complaint: Head Injury
HPI: GOMLZ Hector

Printed Time: 10/26/2007 13:07:33 PM
c 1 of 2
P490943644 DOB:01/01/1851 U U
TRAUMA
VICTIM JW
Adm:00000000 M2581962
Transfer: _____

MODE OF ARRIVAL: ☐ POV ☑ Ambulance ☐ Immobilized PREHOSPITAL ORDERS: _____
SOURCE: ☐ Patient ☐ Family Member ☐ Friend ☑ EMS ☑ Nurse's Notes Reviewed
TIMING: ☐ Began ☐ Occurred ☐ PTA 2 hrs ago ____ days ago ☐ this morning ☐ this afternoon ☐ this evening ☐ during the night ☐ last night ☐ yesterday ☐ Gradual / ☐ Sudden Onset
LOCATION OF INJURY: ☐ None ☑ Head ☐ Face ☐ Mouth ☐ Neck ☐ Chest ☐ Back ☐ Abdomen ☐ Pelvis
Right: ☐ Shoulder ☐ Humerus ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot
Left: ☐ Shoulder ☐ Humerus ☐ Elbow ☐ Forearm ☐ Wrist ☐ Hand ☐ Hip ☐ Thigh ☐ Knee ☐ Lower Leg ☐ Ankle ☐ Foot
CONTEXT: ☐ None Recent: ☐ Alcohol Use / ☐ Illicit Drug Use
TYPE OF ACCIDENT: ☐ MVC ☐ MCA ☐ Peds vs. Auto ☐ Assault ☐ Other:
☐ MVC: ☐ Unrestrained Restrained: (☐ Airbag/ ☐ Shoulder Strap / ☐ Lap Belt) ☐ Driver / ☐ Passenger
☐ Single Vehicle / ☐ Multi Vehicle ☐ Head-On Side Impact: (☐ Driver Side / ☐ Passenger Side) ☐ Rear Impact / ☐ Roll-Over
☐ Ambulatory At The Scene / ☐ Non-Ambulatory / ☐ Ejected
☐ ASSAULT: Alleged Assailant's Name: ☐ Unknown
Method of Assault: ☐ Punched ☐ Kicked ☐ Struck with Object
PRE-HOSPITAL: GCS: ____ ____ ____ At Scene; _____ During Transport _____
INTERVENTION PRIOR TO ED: ☐ None ☑ IV ☐ Splint ☑ Intubation _____ Immobilization with: ☑ C-Collar / ☑ Backboard
SEVERITY ☐ Mild ☐ Moderate ☐ Severe ☐ Pain Free 1 2 3 4 5 6 7 8 9 10 ☐ Unable to quantify
DURATION OF SYMPTOMS: ____ Mins ____ Hrs ____ Days ____ Wks ☐ Intermittent / ☐ Continuous in Nature ☐ Currently Present / ☐ Absent
MODIFYING FACTORS: A = Aggravated by R = Relieved by N = No change with (A R N) Nothing (A R N) C-Collar (A R N) Icepack
(A R N) Lifting (A R N) Activity (A R N) Weight-bearing (A R N) Backboard (A R N) Immobilization
(A R N) Movement (A R N) Splint (A R N) Medication(s):

ASSOCIATED SIGNS & SYMPTOMS: (+) = Report (-) = Denies ☐ None (+ -) LOC (+ -) SOB (+ -) Bleeding (+ -) HA
(+ -) Abdominal Pain (+ -) Back Pain (+ -) Neck Pain (+ -) Laceration (+ -) Chest Pain
Male presents from a construction site s/p being struck in the head by an object that fell from a crane. Pt had LOC then combative
☐ Unable to obtain additional information from patient. Reason: Intubated/unresponsive PCP#: Intubated on scene

ROS: ☐ All Other Systems Reviewed And Negative (unless written or circled)
CONST: Wt. Loss Night Sweats
EYES:
ENT:
CV:
RESP:
GI:
GU:
MS:
SKIN:
NEURO:
PSYCH:
ENDO:
HEMA/LYMPH:
ALL/IMMUN:
OTHER:

PAST MEDICAL/FAMILY/SOCIAL HISTORY:
PMH ALLERGIES: ☐ NKDA ☐ PCN ☐ Sulfa ☐ Codeine ☐ Iodine / IVP Dye
MEDICATIONS: ☐ See Nurse's Note
PAST/CURRENT ILLNESSES: ☐ None
SURGERIES/PROCEDURES: ☐ None ☐ Appy
IMMUNIZATIONS: ☐ UTD ☐ Tetanus >5yrs ☐ Tetanus >10yrs
FH ☐ Negative
SH OCCUPATION: LIVING SITUATION:
HABITS: Alcohol Y N H/O Tobacco Y N H/O Drugs Y N H/O ☐ Counseling Given

PHYSICAL EXAM:
CONSTITUTIONAL: VITAL SIGNS: ☐ Normal ☑ Abnormal ☐ Orthostatic APPEARANCE: ☐ Well ☑ Ill ☐ Poor Hygiene / Grooming
✓ Airway: ☐ Normal ☑ Intubated ☐ Obstructed
✓ Breathing: ☐ Normal ☑ Bagged ☐ Agonal
✓ Circulation: ☑ Carotid Pulse Present ☐ Pulseless
PSYCHIATRIC: ☐ Normal Intubated
SKIN: ☐ Normal 2 cm laceration
EYES: ☐ Normal ☐ Raccoon's Eye ____ mm → ____ mm
H/F/ENT: ☑ Normal ☐ Hemotympany ☐ Midface Instability ☐ Malocclusion

NAVIGATOR PC
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ED RECORD
MVC MULTI - TRAUMA - ASSULT - MALE
EDVISIT

MUSC
171 Ashley Ave. Ch. ...ston, SC 29425
Name:

P490943644 DOB:01/01/1951 U U
TRAUMA
VICTIM JW
Adm:00000000 M2581962

Gomez Hector

THORAX/RESP: ☑ Normal ☐ Unequal Breaths
CV: ☑ Normal ☐ Tachycardic ☐ Diminished Pulses ☐ Hypotensive
ABDOMEN/GI: ☐ Normal ☐ Tender Guaiac (+ -)
GU: ☑ Normal
MS (includes neck and back): ☐ Normal ☑ Neck Tenderness ☐ Back Tenderness → C-spine immobilized
RUE: crush-appearing injury to RUE- tip (R) foot
RLE: Absent to DP (R) hypoPLE- arm
HEMA/LYMPH: ☑ Normal
NEURO: ☐ Normal ☐ Lethargic ☐ Obtunded ☐ Disoriented ☐ Focal Deficit GCS: 3 (Intubated)

MEDICAL DECISION MAKING: ☐ Discussed With Family ☐ Old Chart Requested FINDINGS:

DDX: Skull Fx Hemothorax Flail Chest / Multiple Rib Fxs General Aches Pneumothorax Solid Organ Injury Diaphragmatic Rupture Scapular Fx
Chest Contusion Esophageal Rupture Cervical Strain Traumatic Aortic Dissection Subdural Hematoma Spine Injury Hemorrhagic Shock

LAB PERFORMED: ☐ Labs Essentially Normal Unless Noted Below
☐ CBC: WBC Hg Hct Plts ____ PT / PTT: ____ / ____ ☐ T&S ☐ T&C
☐ CHEMISTRIES: Na K Cl HCO3 BUN Cr Glu
☐ URINALYSIS: pH SG Protein Glu WBCs RBCs Bacteria
☐ ETOH: ____ ☐ URINE DRUG SCREEN
EKG INTERPRETATION: ☐ NSR ☐ No ST Abnormality
☐ Compared To EKG On ___ / ___ / ___; ☐ No Significant Change
RHYTHM STRIP:
PULSE OX INTERPRETATION: ☐ Normal ☐ Hypoxic
IMAGING: ☐ C SPINES ☐ Normal C7-T1 transpar. Fx
☑ CXR: ☐ Normal ☐ PTX ☐ Rib Fx ☐ Widened Mediastinum (B) contusions (R) clavicle fx
☐ ABD SERIES: ☐ Normal (R) foot - multi fractures
☐ PELVIS X-RAY: ☐ Normal
☐ CT of Head: ☐ Normal Comm. bleed, fracture c small epidural
☑ CT of ABD / Pelvis: ☐ Normal multiple pul. nodules, no fractures ☐ Preliminary / ☐ Read By Radiologist
ADDITIONAL PROCEDURES (Done by Physician): ☐ NGT Insertion ☐ Foley Insertion ☐ ABG ☐ See Procedure Note ☐ See Addendum
☐ Blood Transfusion ☐ Venous Cutdown Splint ☐ Application / ☐ Inspection ☐ ABG ☐ Vaso-Active Drips
RE-EVALUATION: Time: ____ ☐ Improved ☐ Worsened ☐ No Change
Pt seen in conjuction c trauma, ortho, and NSG services. Scalp laceration closed by Dr. Marshall (trauma attending). Pt has been hemodynamically stable during ED stay. Pt admitted to ICU.

☐ CRITICAL CARE: I have spent ___ minutes in the direct care of this critically ill patient, excluding procedure time. ☐ Comfort measures only
CONSULTATION: Dr ____ @ ____ Returned @ ____ ; Dr: ____ @ ____ Returned @ ____
To See ____ @ ____ ☐ ED ☐ Hospital ☐ Office Rec.
ADMITTING TEAM:

ATTENDING PHYSICIAN NOTE:

HISTORY:

EXAM:

MEDICAL DECISION MAKING:

FINAL IMPRESSION: (1) Epidural hemorrhage (2) Skull fracture (3) Pulmonary contusion (4) Foot fracture (5) Int fractures (6) Clavicle (7) Spine fracture

DISPOSITION: ☐ Discharge (☐ Improved / ☐ Stable) ☑ Admit Trauma ☐ Transfer ☐ AMA ☐ LWT ☐ LDT ☐ DOA ☐ ED Death
Prescriptions: Follow-up: ☐ PMD
(☑ I performed / ☐ I was present for) the H &P on the patient. I have discussed treatment / management options with the (☐ PA / ☐ NP / ☐ Resident / ☐ Student).

☐ I agree with the documented findings and the plan of care. Comments:
ATTENDING SIGNATURE: [signature]

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"PRGRECRD"

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:25[illegible]

(8:45am)

ATTENDING PHYSICIAN NOTE

Patcom: 490943644
MRN: 2581962
NAME: Hector Gomez

Date: 11/3/07 Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to _____

Upon personally questioning the patient, I can confirm that the following are the key history factors:

_____

Physical Examination: Pulse: 118 (133) BP: 56 Resp Rate: 19 T: 37.9 Input: 3731 Output: 4175

Neuro: Sedated, though arousable
Eyes: PERRL 3mm 065-560
ENT: Intubated on nasal stent
CV: ST
Resp: 95% on CPAP 5/5 FiO2 40% few scattered wheezes
GI/Nutr: soft, NT/ND
CU/Renal: UO 264 cc/hr
MuscSkel:
Skin: intact
Psych:
Other: INR 1.4 PTT 109 Hct 33 WBC 23.1 Plt 110 Na 136 K 3.5 Cl 99 CO2 24 BUN 4 Cr 0.8 Glu 107-117

☐ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☐ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☒ I have personally discussed the case with Dr. Byrd.

NIF -30
RSBI - 99

Diagnoses/Problems

1. Respiratory insufficiency ☐New ☐Improved ☒Unchanged ☐Worsening
2. CHI c EDH ☐New ☐Improved ☒Unchanged ☐Worsening
3. S-process fx C3, T1 ☐New ☐Improved ☒Unchanged ☐Worsening
4. T-process fx - R-shoulder fx ☐New ☐Improved ☒Unchanged ☐Worsening
5. R clavicle fx ☐New ☐Improved ☒Unchanged ☐Worsening
6. Scalp lac ☐New ☒Improved ☐Unchanged ☐Worsening

Management Options/Recommendations:

1. Resp - wean as tolerated, 1/2 minutes of T-piece trials
2. Neuro - Q1 neuro exams. Continue pain control
3. CV - Q1 BP checks
4. GI - NPO. OGT.
5. Renal - Correct lytes
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☒High

☒ Pt is critically ill/injured. I spent 30 minutes providing critical care to this patient.

Overall Condition: ☒Critical ☐Serious ☐Fair ☐Good

[signature] Signature Date 11/3/07

I.D - Continue Vanc / Clafaxim empirically.
Endocrine: Good BG Control on ISS
Continue serial neuro exams.

UMA #19100-13 revised 11/06

prgrecrd1 OTE 700222 Rev. 9/06

PRGRECRD

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/3		Ortho S: ↓ cooperation c exam O: (R)LE: toes warm cap refill < 2 sec pins intact POD #1 primary (R) toes 1, 2, 3, & 5 1) NWB (R)LE 2) Cont. to follow 3) Post elevate (R)LE RL 22 15228

prgrecrd1

OTE 700222 Rev. 9/06

MUSC
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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG FOOT,COMP/MIN 3 VIEWS
Accession #: 5077073

MRN: 002581962
Date Exam Completed: 11/04/2007 15:55
Last Update: 11/05/2007

EXAMINATION: FOOT 11/04/07 15:55:00

ACCESSION NUMBER: 5077073

INDICATION: s/p MVC, multiple fractures of right foot phalanges, s/p pinning, please evaluate alignment

COMPARISON: 11/1/07.

FINDINGS: Frontal, lateral, and oblique views of right foot demonstrate interval K wire fixation of first distal phalanx fracture, second proximal/distal phalanges fractures, third and proximal/distal phalanges fractures, fourth proximal phalanx fracture, and fifth middle/proximal phalanges. Bony detail is obscured by overlying casting material. There is no evidence of hardware failure or complication.

IMPRESSION:

K-wire fixation of multiple right phalanges fractures with no evidence of hardware complication.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

History: s/p MVC

Technologist: ANGIE PALMER

Proxy Signer:

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:43 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
MRN: 002581962
Procedure: DIAG FOOT,COMP/MIN 3 VIEWS
Accession #: 5077073
Date Exam Completed: 11/04/2007 15:55
Last Update: 11/05/2007

Interpreter 1: WILLIAM CONWAY
Interpreter 2: MADELINE LEWIS
Interpreter 3:
Date Dictated:

Authenticating Radiologist: WILLIAM CONWAY
Date Authenticated: 11/5/2007

Transcribed by: Tech IntTalk

MUSC
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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5076936

MRN: 002581962
Date Exam Completed: 11/04/2007 03:51
Last Update: 11/04/2007

EXAMINATION: CHEST 11/04/07 03:51:00

ACCESSION NUMBER: 5076936

INDICATION: extubated and emergently reintubated 11/3, tube retracted since last examination

COMPARISON: 11/3/07

TECHNIQUE: Portable

FINDINGS: Single portable AP view of the chest demonstrates the endotracheal tube to be below the level of the clavicles. The enteric tube is seen looped in the stomach. Right clavicle fracture is again noted. Right upper lung and left basilar airspace opacities may represent evolution of contusions or atelectasis, however, cannot exclude infiltrate.

IMPRESSION:
Endotracheal tube below the level of the clavicles, otherwise, no interval change in lung findings.

VOICE DICTATED BY: Richard L. Coursey, Jr., M.D.
I have reviewed the images and agree with the findings in this report.

History: 27 yo male s/p CHI, extubated and emergently reintubated 11/3, tube retracted 1.5 cm since last cxr

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR
MRN: 002581962

Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5076936

Date Exam Completed: 11/04/2007 03:51
Last Update: 11/04/2007

Technologist: GEORGE MCCUBBINS
Interpreter 1: TIMOTHY ALDER
Interpreter 2: RICHARD COURSEY
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: TIMOTHY ALDER
Date Authenticated: 11/4/2007

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NOV 04 2007

P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

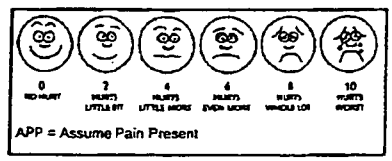
VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

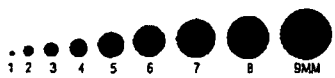
EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # _____





TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL	EYES
08	37°	92	0 / 18		152/76	97					100				3	3	5	5	E	2	
09	37	111	22 / 18		119/75	93					100		Clear liq		3	3	6	6	E	4	
10	37°	115	22 / —		150/91	114					100				4	3	6	6	E	4	
11		120	26 / —		162/92	111					98				4	3	6	6	4	4	
12		126	20 / —		149/85	102					95				4	3	6	6	4	4	
13		116	24 / —		147/81	100					96		D. lactulose		4	3	6	6	4	4	
14	37°	118	21 / —		153/93	114					100		Family @ Bs								
15		114	22 / —		152/92	114					100										
16		113	22 / —		144/84	97					100		D: lactulose		4	3	6	6	4	4	
17	37.2	112	18 / —		153/85	100					97										
18		106	24 / —		142/87	101					97		Family @ Bs								
19		108	26 / —		152/88	103					100				0 4	3	3	6	6	4	4
20	37	104	22 / —		144/79	114					98										
21		117	24		166/91	115					97				4	3	3	6	6	4	4
22		115	22 / —		154/88	108					97										
23		109	24		157/88	109					96										
24	37	102	25		160/85	108					96				4	3	3	6	6	4	4
01		108	21		145/78	99					97					3	3	6	6	4	4
02		102	23		156/76	99					97					3	3	6	6	4	4
03		94	16		148/78	102					100					3	3	6	6	4	4
04	36.8	101	2 / 18		151/84	103					93		labs		4	3	3	6	6	4	4
05		89	1 / 18		146/85	108					98		Intubated ABG		1	3	3	1	1	T	1
06		78	1 / 18		166/79	104					98				3	3	3	5	5	T	2
07		89	— / 18		148/80	103					98		ABG			3	3	5	5	T	2

UP# 411230 rev 8/03

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 04 2007

P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
		RW 7p-7a	

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P:490943644 DOB:01/01/1851 L M
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 04 2007

page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME														BLOOD PRODUCTS COLLOIDS				NUTRITION TYPE	PO	TUBE	INTAKE TOTALS HRLY TOTAL	CUM TOTAL
08	6.1 6	125 125		13.9 14	63 63								3 3					NPO	Ø	Ø	212	212
09	2.8 8	125 250		13.9 27	63 126								3 6						Ø	Ø	208	420
10	1.7 9	125 375											3 9						Ø	Ø	129	549
11	1.6 10	125 500											3 12						Ø	Ø	129	678
12	1.7 11	125 625											3 15						Ø	Ø	129	807
13	2.7 13	125 750											3 21						Ø	Ø	130	937
14	2.2 15	125 875											3 24						Ø	Ø	130	1067
15	1.1 16	125 1000											3 27						Ø	Ø	129	1196
16	1.5 17	125 1125											3 30						Ø	Ø	129	1325
17	1.7 19	125 1250											3 33						Ø	Ø	130	1455
18	2.2 21	125 1375											3 36						Ø	Ø	130	1585
19	2.2 23	500 1875											3 39						Ø	Ø	500	2090
20	2.8 26	125 2000											3 42								131	2221
21	4.5 30	125 2125											3 45								132	2353
22	5.5 36	125 2250											3 48								131	2484
23	5.9 42	125 2375											3 51								131	2615
24	6.3 48	125 2500											3 54								134	2755
01	6.1 54	125 2625											3 57								136	2891
02	5.6 60	125 2750											3 60								134	3025
03	4.6 66	125 2875											3 63								133	3158
04	6.1 72	125 3000											3 66								134	3292
05	6.5 78	125 3125											3 69								133	3425
06	7.2 84	125 3250											3 72								135	3560
07	6.3 90	125 3375											3 75								134	3694

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P:490943644 DOB:01/01/1851 L M
GOMEZ
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24 HOUR CRITICAL CARE PATIENT RECORD Date _____
page 11 of 12

PROGRESS NOTES

Time — Record changes in patient's status and patient/family education

0730 Pt neck & pt @ BS & report rec'd plan today to ~~extubate~~ again. Endorsed pt & SW regarding Dx, meds @ bedside, MD, Pearl Blue, Local & pt. Bilateral & BL. Pt's mother. MD will monitor. Transfer pt per protocol RN 0735 - pt & awake & oriented. Pt's VSS. RN 0740 - pt more awake & able to have deep breaths than 1113. RN 0810 - MD @ BS. RN 0830 - pt's CBG 145 - RN. RN 0900 - pt & alert & oriented, calm. RN 0915 - MD @ BS for rounds. NT & wean to extubate. pt's family @ bedside. RN 1000 - pt @ BS & to extubate. RN 1015 - pt extubated & cont. MD by. pt's sats (90's) pt able to cough & clear secretions. RR 110-115. RN 1020 - pt still on RN 1030 - pt still coughing & clear secretions. RN 1100 - pt still coughing & clear secretions. RN 1100 - MD @ BS pt still coughing & clear secretions. RN 1100 - MD @ SW. RN 1200 - pt able to cough & feel better & side & back pain. Dilaudid & effect for pain. RN 1300 - pt. pt able to still cough & clear self & secretions to clear. pt's sats remain 97-100's RN 1500 - MD & family @ BS. pt & RN 1800 - pt will report to pt. pt & RN 1900 RW to RW report. 2° dsrt V. 1900 Assessment complete. BBS & thoracic throughout. Sinus tach. RLE & cast & good cap refill in toes. Follows commands. Language barrier. No acute distress. VSS. 2200 No acute D's. 2300 NT suctioned 2° to secretions. Tolerates well. VSS. 0200 No acute D's VSS. 0300 Labs. 0345 Pt. agitated. Mouth suctioned. Attempting to NT suction. Pt. respiratory arrest. Bradycardic. Low SpO2. BVM ventilations & 100% O2. HR ↑. SpO2 ↑. Rapid response intubation called. MD @ Bedside. Intubated 7.0 @ 22cm & difficulty. VSS. 0420 ABG. 0500 FiO2 ↑ to .60. VSS. 0600 ABG VSS. 0700 RW to RW report to 2° dsrt V.

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	FC	STOOL	EMESIS	BOGING	RESID			
08	225	225	225			50				
09	450	225	225			"				
10	675	225	225			DK				OGT DC
11	775	100	100							
12	975	200	200							
13	1075	100	100			50				
14	1225	200	200							
15	1375	150	150							
16	1475	100	100							
17	1685	210	210							
18	1835	150	150							
19	2035	200	200							
20	2375	340	340							
21	2700	325	325							
22	2975	275	275							
23	3150	175	175							
24	3300	150	150							
01	3475	175	175							
02	3650	175	175							
03	3750	100	100							
04	3900	150	150							
05	4000	100	100							
06	4060	60	60							
07	4120	60	60							

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 04 2007

page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☑ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position
- ☑ Bed brakes on
- ☑ Bed alarms on
- ☑ Bed heel pressure relief
- ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ Violent behavior
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other _____

○ Any risk criteria identified, implement the **Safety** section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the *medications* below	One of the *medications* below	Two of the *medications* below	Three or more of the *medications* below
SUBTOTAL:	0	2	0	3
TOTAL POINTS:	5	☐ N/A Patient < 6 years old		

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement **Safety** section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE	✓				
A-LINE SITE CARE					
TRACH CARE	✓				
BATH					
FOLEY / PERI CARE	8 KV				
FOLEY D/C'd	✓				
STRAIGHT CATH	✓				
LINEN CHANGE					
SKIN CARE	8 KV				
PEG SITE CARE	✓				
TYPE OF DIET	NPO 8 KV				
% EATEN	✓				
PACING WIRES INSULATED SECURED	✓				
SPECIALTY BED	KV 8				
	Miami JPADS 8KV				

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 04 2007

page 4 of 12

0545
4.4

Vanc trough

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES			HEMATOLOGY				CHEMISTRY								
	TYPE O2 DEL	MODE RATE	FiO2 TV	PEEP PS	CPAP PIP	MIN VENT	A/V PH	PO2 PCO2	HCO3 O2SAT	HCT HGB	WBC RBC	PT PTT	PLT INR	NA K	ICL CO2	GLUC BUN	CREAT CA	MG PHOS		FSBS	
08	V	AC 18	40 550	5																111 .04	08
09	V CPAP		40	5																84 .03	09
10		SL NC																		83 .02	10
11																				107 .02	11
12																				137 .03	12
13																				118 .03	13
14																				96 .02	14
15														142 3.6	110 26	106 4	8 .3	9.1 3.3		85 .03	15
16																				115 .03	16
17																				132 .03	17
18	SL NC																			116 .04	18
19																				131 .04	19
20																				146 .05	20
21																				131 .06	21
22																				139 .07	22
23																				134 .08	23
24																				130 .09	24
01																				141 .1	01
02																				116 .1	02
03																				102 .1	03
04	V	PRVC 14	40 550	5																115 .11	04
05			40				A 7.39	42	21.4 93	24.5 9.2	6.2 2.8	15.2 6.7	1.73 1.4	139 3.3	108 24	90 11	0.7 45	2.3 2.3		110 .11	05
06							B 7.42	78 40	25.6 95.7											120 .12	06
07																				112 .13	07

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VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11 3 07

	Appearance	Location	Dressing	Calibrated Time	
A	S	R Rad	DI	2320	
P			DI	20	

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: PIV 14 Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	L AC	S	DI	+
P	L AC	S	DI	+

Line #2 Type: PIV 16 Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	R Hand	S	DI	+
P	R Hand	S	DI	+

Line #3 Type: PIV 16 Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	R FA	S	DI	+
P	R FA	S	DI	+

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

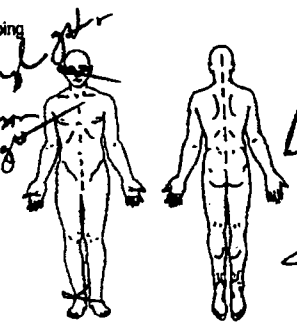
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(A) Pain Score: 4 Patient Goal: 2
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



If any problems identified, implement **Comfort** section of the **POC.**

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

☐ Psychosocial / Spiritual / Education A _____ P M
☑ Comfort A _____ P M
☐ Neurological / EENT A _____ P M
☐ Safety A _____ P M
☐ Functional / Musculoskeletal A _____ P M
☐ Skin / Wound A _____ P M
☑ Cardiovascular A _____ P M
☑ Respiratory A _____ P M
☐ Gastrointestinal A _____ P M
☐ Genitourinary A _____ P M
☐ Nutrition A _____ P M
☐ Discharge Planning A _____ P _____
☐ Other _____ A _____ P _____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE _____ TIME 0730

PM SHIFT ASSESSMENT
SIGNATURE _____ TIME 2000

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NRSRECRD

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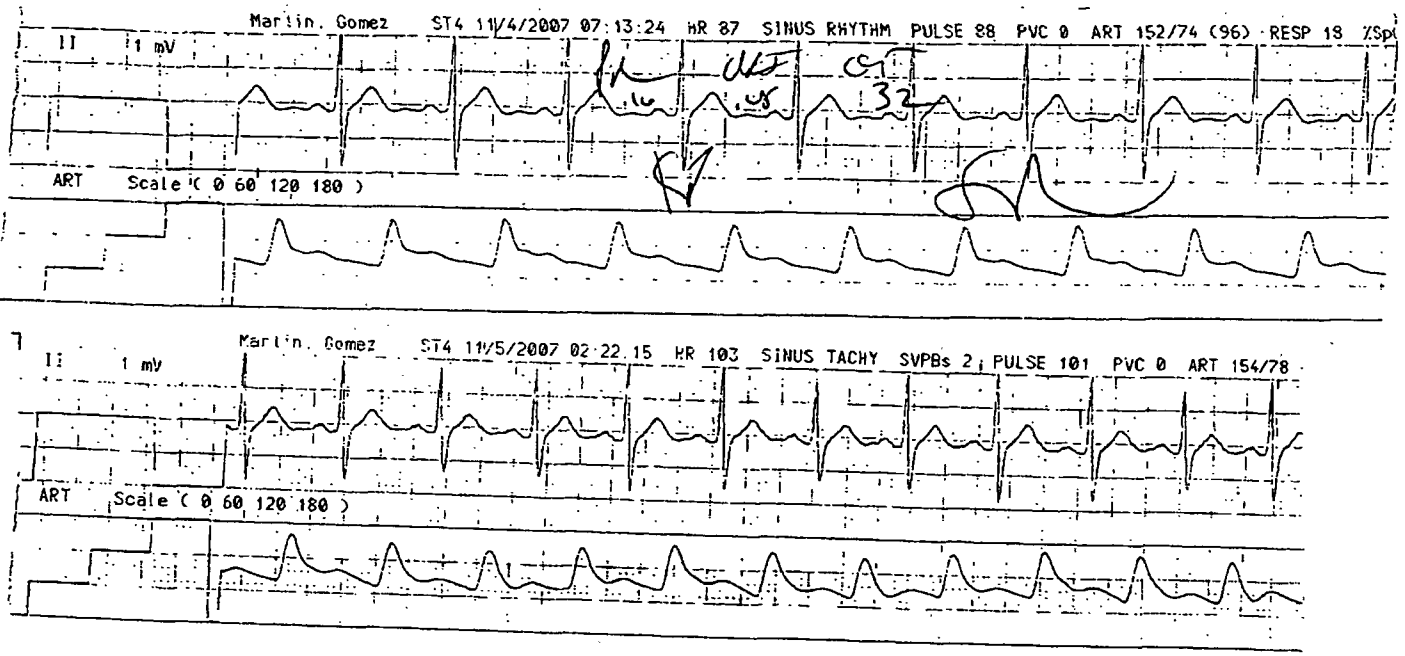
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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 5 of 12

THIS SPACE MONITOR STRIPS



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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 4 2007

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM 1 WD

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT	✓ A/B		LC		S/C	
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

○ Any problems identified, implement **GastroIntestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
○ Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness								
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Site / Type
☐ A ☐ P SCD/foot pump
☐ A ☐ P TED
☐ A ☐ P Traction
☐ A ☐ P Cast/splint
☐ A ☐ P External fixator
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ☐ A ☐ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin impairments
Location
☐ A ☐ P Surgical incision
dressing type/appearance
☐ A ☐ P Drain
☐ A ☐ P Drain
☐ A ☐ P Wound
dressing type/appearance
☐ A ☐ P Other
☐ A ☐ P Other

Wound vac™

	Location	mmHg	Suction
A			
P			

○ Any problems identified implement **Skin/Wound** section of the **POC.**

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 04 2007

(STAMP PLATE)

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location L Head lac
☐ Sutures ☐ Staples ☐ Steri strips c
Drainage amount
☐ None ☐ Scant ☒ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other
Dressing change Time
Dressing type

Surgical Incision #2 Location L Hand
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other
Dressing change Time
Dressing type

Wound #1 Location
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length ____ cm
Width ____ cm
Depth ____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined ____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other
Dressing change Time
Dressing type

Wound #2 Location
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length ____ cm
Width ____ cm
Depth ____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined ____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other
Dressing change Time
Dressing type

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	8	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	S / Th,T	S / Th,T	C / Th,T	C / Th,T	C / T-r	-- / T-r	NTS / Th,T	NTS / Th,T	NTS / Th,T	NTS / Th,T	S / Th,T	S / Th,T
HOB>30 degrees unless contraindicated	✓	✓	—	—	—	—	✓	—	—	—	—	—
A line site ✓	✓	✓	—	—	—	—	✓	✓	✓	—	—	—
IV site ✓	✓	✓	—	—	—	—	✓	✓	—	—	—	—
Chest tube patent ✓	NA	→	→	→	→	→	NA	→	→	→	→	→
NG/OG place ✓	✓	DC	DC	DC	DC	DC	NA	→	→	→	→	→
Mouth care	✓	✓	✓	—	—	—	✓	✓	—	✓	✓	✓
Turn / Passive ROM	—	—	—	—	—	—	✓	✓	✓	✓	✓	✓
Side Rails	4 x 2	→	→	→	→	→	x 2	→	→	→	→	→
Incen. Spir./ deep breathe	vent	DB	DB	DB	DB	DB	enc	→	→	→	vent	→
Alarms on / Assessment reviewed	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ	✓ / KJ

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(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 04 2007

page 7 of 12

NEUROLOGIC / EENT

☐A ☐P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐A ☐P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐A ☐P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐A ☐P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐A ☐P Glasgow coma scale < 15 in non-sedated state.

☐A ☐P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	2	2	2	2
P	2	2	2	2

Reflexes Absent

☐A ☐P Cough ☐A ☐P Gag

☐A ☐P Corneal

Drainage

☐A ☐P Otorrhea ☐A ☐P Rhinorrhea

☐A ☐P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☐A ☐P Cervical collar Miami J

☐A ☐P Cervical traction

☐A ☐P Halo

☐A ☐P Tongs

☐A ☐P Shunt: _____

☐A ☐P Codman reference # _____

☐A ☐P Other _____

Impairments

☐A ☐P Hearing

☐A ☐P Eyes

☐A ☐P Unable to assess

Fontanel

☐A ☐P Full ☐A ☐P Bulging

☐A ☐P Sunken

Emotional status

☐A ☐P Inconsolable

Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐A ☐P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐A ☐P Arrhythmia SR 90's

☐A ☐P Click

☐A ☐P S3

☐A ☐P Distant heart sounds

☐A ☐P S4

☐A ☐P Rub

☐A ☐P Capillary refill > 3 sec.

Murmur

☐A ☐P Faint

☐A ☐P Moderate

☐A ☐P Loud

☐A ☐P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A	WNL				
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	1	1	1	1	Periorbital
P					

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	2	2	2	2	
P					

Pacemaker / wires

☐A ☐P Permanent ☐A ☐P Transvenous

☐A ☐P Transcutaneous ☐A ☐P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐A ☐P PA catheter

☐A ☐P AICD

Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐A ☐P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☐A ☐P: Suction functioning

☐A ☐P: Ambu bag/mask present

Abnormal Findings

Respirations

☐A ☐P Labored ☐A ☐P Shallow

☐A ☐P Irregular ☐A ☐P Orthopnea

☐A ☐P Stridor ☐A ☐P Pleural rub

☐A ☐P Accessory muscle use

☐A ☐P Chest excursion asymmetrical

Tracheal deviation

☐A ☐P Right ☐A ☐P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	C	C	D	C	D
P	R	R	R	R	R

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	7.5	—	22 cm
P				

☐A ☐P Emergency trach supply box

☐A ☐P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

Any problems identified, implement **Respiratory** section of the POC.

UP# 411230 rev 8/03

PRGRECRD

MUSC
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P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/4/07		NSurgAdm
		28? 90'-129 134/82
0210		28 12/160 25
		PE: Intubated 7.34/163/42/22
		⊕ Pink ~~Orange~~ Dyes (+) Corneals
		Lox (B)LE WD EXE
		C-collar in place
		IAP: Sp MVC & (L) transparent skull fx
		- cont ABS
		- will need f/u Ex C-spine films once LOC improves.
		ISSG1
11/4		Ortho
		Si intubated / sedate
		Oi (R)LE: elevated
		splint c/o I
		~~Capref~~ Cap refill < 2 sec
		POD #2 percutaneous pinning (R) Malleolus
		1, 2, 3, & 5
		cont NWB
		AL-2
		15225

prgrecrd1

OTE 700222 Rev. 9/06

PRGRECRD

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P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

(9:15am)

ATTENDING PHYSICIAN NOTE

Patcom: 490943644
MRN: 2581962
NAME: Hector Gomez

Propofol 30 ~~Ivac~~ Vanc
Fentanyl 50 mg/hr Keppra clafoxm
Repeat Consult

Date: 11/4/07 In-sh-stf Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held. NSE 20 x cil @ ccliv.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to _____

Upon personally questioning the patient, I can confirm that the following are the key history factors:

Physical Examination Pulse: 82 BP: 154 Resp Rate: 18 T: 98.6 Input: 3934 Output: 7470

Neuro: Sedated. IV. 6770 OGT- 700
Eyes: Tracks
ENT:
CV: RRR
Resp: CTAB. 4 | 5A | TCPS
GI/Nutr: Bilat rales OT- 548
CU/Renal:
MuscSkel:
Skin: Scab on (R) ear 6 | 36 | 110 | 139 | +12 | 4 | 90 / 28 | | | 5.4 | 24 | 6.5
Psych:
Other: MUTT- CIWA- SAH-

☐ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☐ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☒ I have personally discussed the case with Dr. Hand.

Diagnoses/Problems

1. Respiratory insufficiency ☐New ☐Improved ☒Unchanged ☐Worsening
2. CVA c TENA ☐New ☐Improved ☒Unchanged ☐Worsening
3. CVA c Aphasia ☐New ☐Improved ☒Unchanged ☐Worsening
4. R-Parietal Mass - R SAH ☐New ☐Improved ☒Unchanged ☐Worsening
5. Bicycle Fx ☐New ☐Improved ☒Unchanged ☐Worsening
6. (L) Scalp Lac ☐New ☒Improved ☐Unchanged ☐Worsening

Management Options/Recommendations

1. Respiratory - suctioning pocketers. Ted Secretions
2. MICU - evaluate after this cx.
3.
4. CV - (R) ICC-ES
5.
6. GI - D/C OGT once est. fed.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☒High

☒ Pt is critically ill/injured. I spent 30 minutes providing critical care to this patient.

Overall Condition: ☒Critical ☐Serious ☐Fair ☐Good

Resid- discuss c Sen MD
auto-discussion

Signature Date 11/4/07

F/U- Cardiac Surg
Endocrine - Cardiac Insulin stf

UMA #1910-13 revised 11/06

pn

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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5077232

MRN: 002581962
Date Exam Completed: 11/05/2007 04:18
Last Update: 11/05/2007

EXAMINATION: PORTABLE CHEST 11/05/07 04:18:00

ACCESSION NUMBER: 5077232

INDICATION: CLOSED HEAD INJURY, SKULL FRACTURE, RE INTUBATION STATUS POST RESPIRATORY ARREST

COMPARISON: 11/4/07

FINDINGS: Single frontal radiograph of the chest demonstrates interval placement of endotracheal tube with tip overlying the superior vena cava. Stable size and contour of the cardiomediastinal silhouette. Hila and lungs demonstrate contusions within the upper lobes and left lower lobe atelectasis. Visualized portions of the bony thorax demonstrate right clavicle fracture.

IMPRESSION:

1. Contusions within both upper lobes and left lower lobe atelectasis, all unchanged.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW
I have reviewed the images and agree with the findings in this report.

History: CHI, skull fx

Technologist: GENE BRUNSON

Proxy Signer:

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR **MRN:** 002581962

Procedure: DIAG CHEST PORTABLE 1 VIEW
Date Exam Completed: 11/05/2007 04:18

Accession #: 5077232
Last Update: 11/05/2007

Interpreter 1: STEPHEN SCHABEL
Interpreter 2: MARQUES BRADSHAW
Interpreter 3:
Date Dictated:

Authenticating Radiologist: STEPHEN SCHABEL
Date Authenticated: 11/5/2007

Transcribed by: Tech IntTalk

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5077066

MRN: 002581962
Date Exam Completed: 11/05/2007 03:22
Last Update: 11/05/2007

EXAMINATION: PORTABLE CHEST 11/05/07 03:22:00

ACCESSION NUMBER: 5077066

INDICATION: TRAUMA VICTIM STATUS POST EXTUBATION WITH PERSISTENT RESPIRATORY DISTRESS AND INCREASED BREATH SOUNDS

COMPARISON: 11/4/07 AND 11/1/07

FINDINGS: Single frontal radiograph of the chest demonstrates normal size and contour of the cardiomediastinal silhouette. Hila and lungs demonstrate persistent right and left upper lobe airspace opacity consistent with pulmonary contusions seen on prior Chest CT. Subsegmental atelectasis of the left lower lobe. Visualized portions of the bony thorax demonstrate fracture of right mid clavicle.

IMPRESSION:

1. Bilateral upper lobe contusions (right greater than left).
2. Left lower lobe atelectasis.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW
I have reviewed the images and agree with the findings in this report.

History: Trauma victim s/p extubation with persistent respiratory distress and increasedbreathsounds

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR **MRN:** 002581962

Procedure: DIAG CHEST PORTABLE 1 VIEW Date Exam Completed: 11/05/2007 03:22

Accession #: 5077066 Last Update: 11/05/2007

Technologist: GENE BRUNSON

Interpreter 1: STEPHEN SCHABEL

Interpreter 2: MARQUES BRADSHAW

Interpreter 3:

Date Dictated:

Proxy Signer:

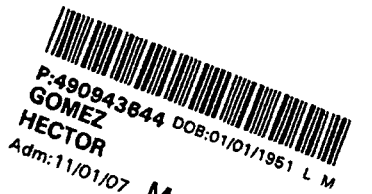
Authenticating Radiologist: STEPHEN SCHABEL

Date Authenticated: 11/5/2007

Transcribed by: Tech IntTalk

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NOV 05 2007



24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

and fentanyl drip started @ 25micrograms/hr (LB) 2330 Linens Δ'd, pt cleaned & comfort bath, PIV #18 placed (L) FA ⊕Blood ⊕flush (SR) 0015 ◊ Changes in assessment (SR) 0330 Labs sent and created from 0100. Insulin drip continues, Propofol continues, fentanyl continues (SR) 0600 Dr Morgan @ bedside to examine pt. Please see progress noted (SR) 0730 Report given to dayshift RN orders reviewed (SR)

Signature / Shift	Initials	Signature / Shift	Initials
PBlvRN		[signature] 7p-7a	(SR)

UP# 411230 rev 8/03

* N R S R E C R D *

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 5 2007

page 2 of 12

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

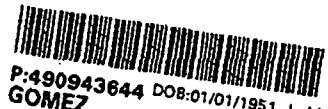
IV SOLUTIONS / ADDITIVES

TIME	Insulin 250 units/250ml	Propofol 1000mg/100ml	MIVF	IV meds	Fentanyl 2.5mg/50cc						NS flush	BLOOD PRODUCTS COLLOIDS				NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	6.8	18.5	125	163							3								216	216
09	9.1	18.5	-	150							3								277	493
10	9.8	20	-	220							3								281	774
11	8.5	20.5	125	-							3								155	929
12	7.1	15.4	-	150							3								183	1112
13	6.7	15.4	125	315							3								160	1272
14	6.3	12.5	-	250							3								284	1556
15	5.3	25	-	250							3								284	1840
16	4.5	25	125	500							3								159	1999
17	3.2	25	125	625							3								156	2155
18	2.7	25	-	500							3								82	2237
19	1.5	30	125	750							3								165	2402
20	1.8	30	125	875							3								170	2572
21	1.8	33	DW	250							3								292	2864
22	1.4	33		250	.5						3								292	3156
23	1.4	33	125	1000	.5						3								166	3322
24	1.1	33	125	1125	1						3								170	3492
01	1.1	33	125	1250	.5						3								169	3661
02	1.3	33	125	1375	.5						3								168	3829
03	1.4	33	125	1500	.5						3								165	3994
04	1.5	33	125	1625	.5						3								166	4160
05	1.6	33	125	1750	.5						3								165	4325
06	1.7	33	125	1875	.5						3								167	4492
07	1.7	33	125	2000	.5						3								167	4659

UP# 411230 Rev 8/03

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NOV 05 2007



24 HOUR CRITICAL CARE PATIENT RECORD Date _____
page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0730 Assessment complete. Eyes open to command, purposeful localizing. Nods appropriately to questions. PERRL. Lungs c coarse rhonchi, thick creamy yellow sputum noted. Vent settings confirmed. Tele SR. Palp pulses D x R. foot. Great toe pink, warm, brisk cap refill. 3 middle toes blue, warm. All x pinkie toe c pins. Abd soft, nontender, bowel sounds active 4/4. Foley to gravity draining clean yellow urine. L scalp lac c sutures, prev drain, Ø output. PB 0815 NG placed to ~~ver~~ R nare, placement verified c ⊕ air bolus. Place to LWS. PB
0815 PEEP ↑ 8. PB 0845 Sputum cx collected via ET suction. PB
1010 18# PIV placed to R upper arm. ⊕ blood return, flushed c resistance. PB
1550 Pt bathed, skin care complete. Pt reassessed. ΔS, ao noted. PB
1810 R rad Aline wave flat, Ø blood return, line dcd. L pedal Aline placed. PB

1845 Report received Pt care assumed. Assessment in progress. RB
2105 Assessment complete and charted per flowsheet. Pt sedated on propofol @ 60 micrograms/kg/min. Pt will open eyes when spoken to and is purposeful. PERRL. Pt intubated rhonchi throughout thick yellow sputum suctioned out of ETT. R foot casted great toe is warm ⊕ cap refill 3 middle toes are blue but warm. MD aware. NGT to LCWS. Bx to AR drainage noted. L scalp lac has sutures and serosanguinous drain. Will continue to monitor. RB 2110 Pt very agitated. MD @ bedside. Propofol 1 to 70 micrograms/kg/min

UP# 411230 rev 8/03

NRSRECRD

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P:490943644 DOB:01/01/1951 L M

NOV 05 2007

GOMEZ
HECTOR

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

Adm:11/01/07 M:2581962

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
B'k = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS								BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	FOLEY	STOOL	EMESIS	NG/G	RESID										
08	120	120	120														
09	320	200	200 320			Ø											
10	470	150	150 470														
11	745	275	275 745														
12	1015	320	270 1015			200 200											
13	1125	60	110 1125														
14	1200	75	75 1200														
15	1380	180	180 1380														
16	1625	245	245 1625			100 300											
17	1785	160	160 1785														
18	1960	175	175 1960														
19	2000	40	40 2000														
20	2350	350	180 2180			350 350											
21	2450	100	100 2280														
22	2530	80	80 2360														
23	2605	75	75 2435														
24	2720	115	115 2550														
01	3030	310	480 3030			350 850											
02	3060	30	30 3060														
03	3135	75	75 3135														
04	3175	40	40 3175														
05	3275	100	100 3275														
06	3360	385	385 3510			350 1150											
07	3380	30	30 3540														

UP# 411230 rev 8/03

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NOV 05 2007

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☐ Allergy band on
- ☑ Call system accessible
- ☐ Bed in low position
- ☐ Bed brakes on
- ☐ Bed alarms on
- ☐ Bed heel pressure relief
- ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☐ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☑ Patient at high risk for infection
  - ☐ Immunocompromised
  - ☑ Other vent, invasive line
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ *Cognitive impairment/altered mental status*
  - ☐ *Violent behavior*
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other _____
- ☑ Any risk criteria identified, implement the **Safety** section of the **POC.**

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	(59)	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose sedated	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/dx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history unknown	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below
SUBTOTAL:	-	3	-	3
TOTAL POINTS:	6	☐ N/A Patient < 6 years old		

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

☑ If score ≥ 6, implement **Safety** section of the **POC.**

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION	1000 18ga LAM		PIV #18 LFA
IV SITE CARE LOCATION			
IV TUBING CHANGE			All tubing Δ'd
PICC LIMB CIRCUMFERENCE			
A-LINE SITE CARE			Placed 11/5
TRACH CARE			N/A
BATH	1600 PB		Comfort 2330 (B)
FOLEY / PERI CARE	1600 PB		2330 (B)
FOLEY D/C'd			N/A
STRAIGHT CATH			N/A
LINEN CHANGE	1600 PB		2330 (B)
SKIN CARE	1600 PB		2330 (B)
PEG SITE CARE			N/A
TYPE OF DIET	NPO		NPO
% EATEN			Ø
PACING WIRES INSULATED SECURED			N/A
SPECIALTY BED			ICU
Meaning Dads	1600 PB		2330 (B)

UP# 411230 rev 8/03

* N R S R E C R D *

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NOV 05 2007

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 4 of 12

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm: 11/01/07 M:2581962

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

0300
Random Vanc 13

	VENTILATION					BLOOD GASES				HEMATOLOGY					CHEMISTRY									
TYPE O2 DEL	MODE RATE	FiO2 TV	PEEP PS	CPAP PIP	MTN VENT	A/V PH	PO2 PCO2	CO2 O2SAT		HCT HGB	WBC RBC	PT PTT	PLT INR		NA K	CL CO2	GLUC BUN	CREAT CA	MG PHOS		FSBS		
V	PRVC 18	100	5																				08
		550				A	92	93	38	24.3	97												09
	V35%		18																				10
						A	98	90	38	24.5	97												11
																							12
																							13
																							14
																							15
																							16
																							17
																							18
																							19
V	PRVC 18	55	5																			103	20
		550																				100 .14	21
																						91 .13	22
																						115 .14	23
																						113 .15	24
						A	7.45	73	38	24.3	91.8	81.5	7.2	8.01	2.48	305	139	2.9	116	36	99	15	.8	83	2.1	2.8	158 .15	01
																						104 .15	02
																						85 .14	03
																						97 .11	04
																							05
																						105 .13	06
																						104 .13	07

UP# 411230 rev 8/03

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NOV 0 5 2007

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at introducer
A					
P					

Arterial line Date inserted: 11/5/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	Rad	CDI	0730	⊕ wave, ⊖ waveform
P	Secure ⊖ Radial	D.I	2000	⊕ Blood ⊕ wave	

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: PIV L upper arm 19# Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	L upper arm	S	CDI	-
P	⊖ Brachial	Secure	D.I	⊖

Line #2 Type: PIV 20# Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	L hand	S	CDI	-
P		D/C'd @ 1930		

Line #3 Type: PIV 18# Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	R wrist	S	CDI	-
P				

Line #4 Type: PIV # 18 Insert Date: 11/5/07

	Site	Appearance	Dressing	Blood Return
A				
P	⊕ upper arm	Secure	D.I	⊕

COMFORT

☐ A ☐ P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

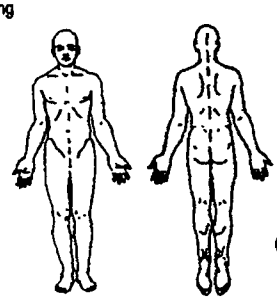
Abnormal Findings

☐ A ☐ P Nausea ☐ A ☐ P Itching ☐ A ☐ P Chills
☐ A ☐ P Fever ☐ A ☐ P Sweating ☐ A ☐ P Difficulty sleeping
☐ A ☒ P Pain ☐ A ☐ P Receiving analgesic therapy

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐ A ☐ P New ☐ A ☐ P Ongoing

Pain Description
☐ A ☐ P Dull ☐ A ☐ P Constant
☐ A ☐ P Burning ☐ A ☐ P Cramping
☐ A ☐ P Stabbing ☐ A ☐ P Radiating
☐ A ☐ P Throbbing ☐ A ☐ P Tingling



Location of pain (on the diagram, put an X on the area where the patient complains of pain)

○ Any problems identified, implement **Comfort** section of the **POC**.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

☐ **Psychosocial / Spiritual / Education** A_____ P_____
☒ **Comfort** A M P M
☒ **Neurologic / EENT** A M P M
☒ **Safety** A M P M
☒ **Functional / Musculoskeletal** A M P M
☒ **Skin / Wound** A M P M
☒ **Cardiovascular** A M P M
☒ **Respiratory** A M P M
☒ **Gastrointestinal** A M P M
☒ **Genitourinary** A M P M
☐ **Nutrition** A_____ P_____
☐ **Discharge Planning** A_____ P_____
☐ **Other** _____ A_____ P_____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE [signature] TIME 0730

PM SHIFT ASSESSMENT
SIGNATURE [signature] TIME 1905

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NRSRECRD

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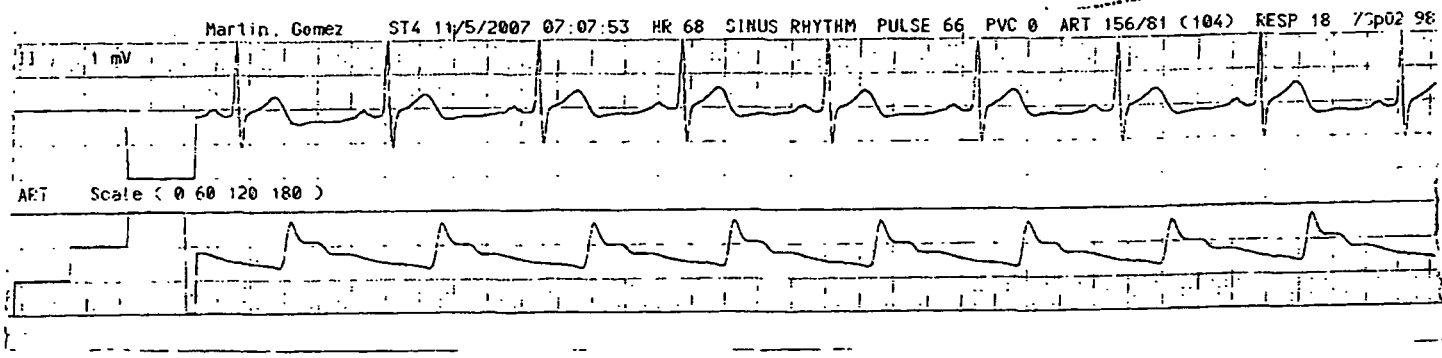
NOV 05 2007

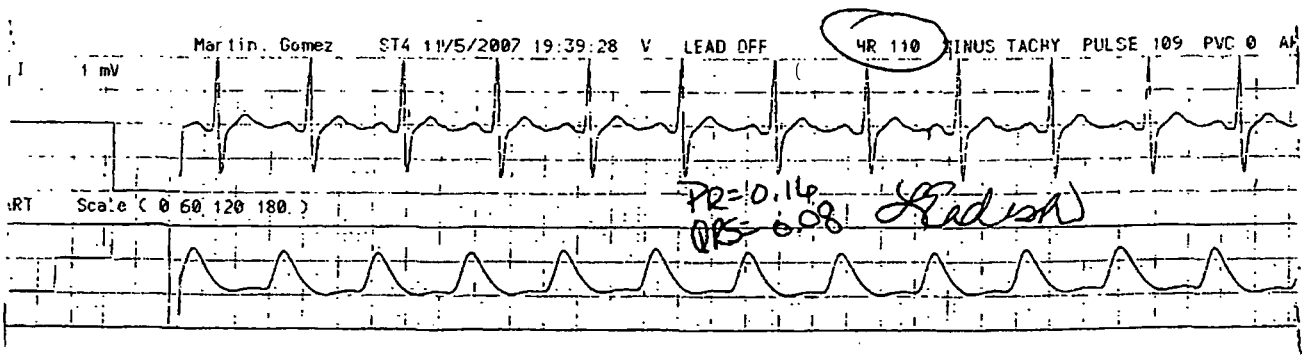
24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 5 of 12

THIS SPACE FOR MONITOR STRIPS NOV 05 2007

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GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM PTA

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☒ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT		(+)		LC		Bg
OGT						
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

☒ Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P *Menses*

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P *Condom* ☒ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P *Concerns about sexual function*
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
☒ *Any problems identified, implement* **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

~~Antepartum~~ _____ # weeks gestation

☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. *Small to moderate* lochia. *Perineum* intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness								
Contractures								
Paralysis								
Non wt bearing					X	X		

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Site / Type
☒ A ☐ P SCD/foot pump LLE
☐ A ☐ P TED
☐ A ☐ P Traction
☒ A ☐ P ~~Cast/splint~~ RLE
☒ A ☐ P ~~External fixator~~ R toe - PINS
☐ A ☒ P Other cast - heel - RLE

Speech ETT
☐ A ☐ P Slurred ☒ A ☐ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale
☐ A ☐ P Cyanotic
☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose
☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool
☐ A ☐ P Diaphoretic

Skin Impairments
Location
☐ A ☐ P Surgical incision _____
dressing type/appearance _____
☒ A ☐ P Drain Penrose, scalp
☐ A ☐ P Drain _____
☒ A ☐ P Wound scalp IOC, sutures
dressing type/appearance well approximated
☒ A ☐ P Other R toes - pins
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

☒ Any problems identified implement **Skin/Wound** section of the **POC.**

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page 6 of 12

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	Sx ThY	Sx ThY	Sx ThY	Sx ThY	Sx ThY	Sx ThY	Sx TK.Y	Sx TK.Y	Sx ϕ	Sx G	Sx G	Sx
HOB>30 degrees unless contraindicated	✓	✓	✓	✓	✓	✓	ϕϕ	ϕϕ	ϕϕ	IOHB	OHB	IOHB
A line site ✓	✓	✓	✓	✓	✓	✓	ϕϕ	ϕϕ	ϕϕ	IOHB	IOHB	IOHB
IV site ✓	✓	✓	✓	✓	✓	✓	ϕϕ	ϕϕ	ϕϕ	IOHB	IOHB	IOHB
Chest tube patent ✓	NA						N/A					
NG/OG place ✓	NA	⊕air			⊕air		ϕϕ	ϕϕ	ϕϕ	IOHB	IOHB	IOHB
Mouth care	✓	✓	✓	✓	✓	✓	ϕϕ	ϕϕ	ϕϕ	IOHB	IOHB	IOHB
Turn / Passive ROM	✓	✓	✓	✓	✓	✓	ϕϕ	ϕϕ	ϕϕ	IOHB	IOHB	IOHB
Side Rails	X2	X2	X2	X2	X2	X2	X2	X2	X2	X2	X2	X2
Incen. Spir./ deep breathe	✓	✓	✓	✓	✓	✓	Vent	Vent	Vent	Vent	Vent	Vent
Alarms on / Assessment reviewed	PO BTB	PO BTB	PO BTB	PO BTB	PO BTB	PO BTB	ϕϕ	ϕϕ	ϕϕ	IOHB	IOHB	IOHB

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page 7 of 12

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.
☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.
☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA
☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.
☒ A ☒ P Chemical paralysis/sedation Propofol

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A				
P	2	2	2	2

Reflexes Absent
☐ A ☐ P Cough ☐ A ☐ P Gag
☐ A ☐ P Corneal

Drainage
☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea
☐ A ☐ P Eye
1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices
☒ A ☐ P Cervical collar Miami J
☐ A ☐ P Cervical traction
☐ A ☐ P Halo
☐ A ☐ P Tongs
☐ A ☐ P Shunt: _____
☐ A ☐ P Codman reference # _____
☐ A ☐ P Other _____

Impairments
☐ A ☐ P Hearing
☐ A ☐ P Eyes
☐ A ☒ P Unable to assess

Fontanel
☐ A ☐ P Full ☐ A ☐ P Bulging
☐ A ☐ P Sunken

Emotional status
☐ A ☐ P Inconsolable

☒ Any problems identified, implement **Neurologic / EENT** section of the **POC**.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart
☐ A ☒ P Arrhythmia ST
☐ A ☐ P Click
☐ A ☐ P S3
☐ A ☐ P Distant heart sounds
☐ A ☐ P S4
☐ A ☐ P Rub
☐ A ☐ P Capillary refill > 3 sec.

Murmur
☐ A ☐ P Faint
☐ A ☐ P Moderate
☐ A ☐ P Loud
☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	+trace		+1		
P	+1	+1	+1	+1	

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A		DP			
P	+2	DP	+2	+2	

Pacemaker / wires
☐ A ☐ P Permanent ☐ A ☐ P Transvenous
☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial
Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter
☐ A ☐ P AICD

☒ Any problems identified, implement **Cardiovascular** section of the **POC**.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.
☒ A ☒ P: Suction functioning
☒ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations
☐ A ☐ P Labored ☐ A ☐ P Shallow
☐ A ☐ P Irregular ☐ A ☐ P Orthopnea
☐ A ☐ P Stridor ☐ A ☐ P Pleural rub
☐ A ☐ P Accessory muscle use
☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation
☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	R	R	R
P	R	R	D	R	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ET	7.0		24 cm
P	ETT	7.0	—	22cm @teeth

☐ A ☐ P Emergency trach supply box
☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage
S=serous; SS=serosanguinous; B=bloody; P=purulent
Air leak / SQ emphysema
P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☒ Any problems identified, implement **Respiratory** section of the **POC**.

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* N R S R E C R D *

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(STAMP PLATE)

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

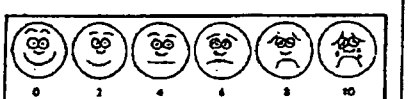
VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

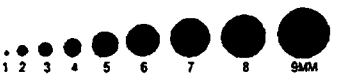
EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # 5





TIME	TEMP	PULSE	SPON VENT RESP	CUFF BP	A-LINE BP	MAP PCWP	CVP	PA	CO C	SVR	S_vO_2	ICP HI LOW	F35	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS SIZE L	MOTOR REACTION R	MOTOR REACTION L	VERBAL EYES
08	98.4	79	1 / 18		116/81	103					97		107	OG placed	0 / 3	4 B	4 B	5	5	ET 3
09		81	- / 18		118/79	101					99		117							
10		84	- / 18		153/77	100					100		106							
11		110	10 / 18		153/77	103					100 91		96							
12	98.5	87	- / 18		139/74	96					96		113			5 B	5 B	5	ET	3
13		91	- / 18		135/71	91					95		109							
14		86	- / 18		139/74	95					95		104							
15		105	3 / 18		150/78	98					96		107							
16	98.6	98	6 / 18		153/82	102					94		97			5 B	5 B	5	ET	3
17		103	6 / 18		139/80	111					93		96							
18		104	- / 18		136/58	105					95		107	Pedal Aline placed						
19		93	- / 18		133/60	80					95		115							
20	99.8	111	6 / 18		141/65	87					94			Levo @ 2 Meds ☑	LUE 5	4 B	4 B	5	T	3
21		96	3 / 18		134/64	82					94									
22		114	3 / 18		133/66	80					95									
23		102	0 / 18		109/59	75					94									
24	37.3	116	5 / 18		132/58	78					94			Meds ☑	LUE	5 B	5 B	5	T	2
01		102	0 / 18		121/56	79					95									
02		89	0 / 18		107/58	74					96			~~Labs~~ ☑						
03		82	- / 18		106/60	74					95									
04	98	72	- / 18		131/59	78					48									
05		69	- / 18		150/63	82					97									
06		93	1 / 18		152/64	87					100									
07		86	- / 18		130/55	74					95									

"PRGRECRD"

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P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	STICU
11/5/07	0645	27 had episode of respiratory failure overnight that required reintubation. He had been extubated for approx. 18h yesterday & copious secretions but had been clearing appropriately. He began requiring a lot of suction.
		37 $\frac{2}{}$ 36° 89 18 166/80 98% PRVC 550/18/5/60%
		3694 | 4120
		Gen: NAD, intubated, sedated & FC.
Insulin		HEENT: ET in place.
1/2 NS @ 20 cc/hr		Neck: Miami J in place.
Propofol 40 mg		CV: RRR s M/G/R
Pepcid		Lungs: Coarse BS @.
Combivent		Abd: soft, NT, nd @bs
Claforan		G-U: Foley in place.
Keppra		Extrem: RLE Elevated, splint C/D/I.
Versed		LLE: SCD in place.
		2 Lips. 7.42/40/78/95.2% 8.2 / 6.2 / 29.5 / 138/108/11/40 / 3.3/24/0.7
		A/P: 26 y/o HM s/p MVA accident. 8.5 / 23
		1. Resp: Cont weaning FiO2. We would like to see a PaO2 on current settings before we reduce FiO2 to a non-toxic level. We will plan to downsize trach cuff w/i a few hours.
		2. Neuro: Cont Versed / Claforan for Skull fx. Will cont to follow neuro exams. He was appropriate when awake yesterday
		3. Ortho: NWB RLE. PT when appropriate
		4. ID: cont abx as above. Temp trend 4. 4. Will follow

prgrecrd1

OTE 700222 Rev. 9/06

"PRGRECRD"

MUSC
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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1851 L M
TRAUMA
VICTIM JW
Adm:11/01/07 M:2581962

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/5	07	Ortho - Staff
	0710	—
		Intubated, Sedated.
		Splint RLE intact.
		Toes cyanotic but c/n 2sec.
		Pin sites clear & drainage.
		A/P Post CRPP ⓡ 1,2,3,5 phalanx Fx's, CMI c cervical Fx, Resp. failure post extubation
		- elevate, splint
		- pin care
		- NWB
		- 2° survey when pt awake

prgrecrd1

OTE 700222 Rev. 9/06

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

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Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
		IVSL @ 6
11/5/07		27' 80'-110's 36.9Y//4/120
0827		Cyanosis ++ A~ Na 138 Plt 173
		L-L @ BLE. BMP 1.16
		WD L LE
		Not FC's
		Ant: Sp MVC à ck-lk
		- Cont ABS
		- will Rec. Ct.
		[illegible]
		[illegible]

prgrecrd1

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"PRGRECRD"

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

ATTENDING PHYSICIAN NOTE

MRN: 2581962
NAME: Gomez, Hector

Date: 11-5-07 Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History: S/P coma to neck

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to PRVC 18 550 8 55%

Upon personally questioning the patient, I can confirm that the following are the key history factors: 7.42/38/93

Physical Examination: Pulse: 89 BP: 144/74 Resp Rate: ____ T: 37.2 Input: 3641 Output: 4120

Neuro: sedated, intubated
Eyes:
ENT:
CV: RRR, ↓ ↑ ② prop gtt @ 55
Resp: Coarse ⑤
GI/Nutr: soft NB/NT/+BS
CU/Renal: 62 245 175
MuscSkel:
Skin: 2+ @ DP pulses
Psych:
Other: + 11 0.7 90

☒ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☒ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☐ I have personally discussed the case with ____

Diagnoses/Problems

1. Respiratory failure - intubated but might ☐New ☐Improved ☒Unchanged ☐Worsening
2. ~~CHF~~ Shock Resolved + Hx CHF ☐New ☐Improved ☐Unchanged ☐Worsening
3. Chronic + Acute systolic dysfunction/transplant Hx ☐New ☐Improved ☒Unchanged ☐Worsening
4. ☐New ☐Improved ☒Unchanged ☐Worsening
5. ☐New ☐Improved ☐Unchanged ☐Worsening
6. ☐New ☐Improved ☐Unchanged ☐Worsening

Management Options/Recommendations

1. Add Levo ↓
2. FU Resp Cultures
3.
4.
5.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☒High

☒ Pt is critically ill/injured. I spent 30 minutes providing critical care to this patient.

Overall Condition: ☒Critical ☐Serious ☐Fair ☐Good

Signature ____ Date ____

UMA #19100-13 revised 11/06

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STAMP PLATE AREA

P490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M2581962

PRGRECRD
INTERDISCIPLINARY PROGRESS NOTES
PHARMACOKINETIC EVALUATION
(Page 1 of 2)

Patient Name Hector Gomez
MRN 2581962

Evaluation requested by: STICU service

Medication evaluated: Vancomycin

Comments (include current regimen and pertinent laboratory and clinical data):
26yo male w/skull fracture; meningitis ~~Edgecomb~~, prophylaxis treatment. Also treating w/ Cefotaxime 2gm Q6°. WBC: 15 (11/1), 6 (11/6) Scr: 1.2 (11/1), 0.7 (11/5) Tmax: 38.5 (11/1), 37.1 (11/6)

Wt (actual): 89.6 kg **Ht:** 64 cm **IBW:** 59.2 kg **Dosing wt** 89.6 kg

Serum concentration (☑ trough ☐ peak ☐ random) drawn at 0535 (time) on 11/5/07 (date) reported as 4.9 mcg/mL (desired 15-20 mcg/mL).

Serum concentration (☐ trough ☐ peak ☐ random) drawn at _____ (time) on _____ (date) reported as _____ (desired _____).

Steady-state concentration? ☑ Yes ☐ No

Summary of dosing (if not steady-state):

Volume of distribution: 62.7 L/kg ☑ Calculated ☐ Estimated

Elimination rate (k_e): 0.155 hr^{-1}; **half-life:** 4.47 hr

Assessment: Expected trough was much lower due to ~~increased~~ underestimation of CrCl and pt. was originally thought to be 56 yo. The new dose should produce a trough ≈ 17 mcg/mL.
- Verify duration of prophylaxis with neuro

Recommendations:

☐ Continue current regimen. No further serum concentrations needed unless patient's condition changes.

☐ Continue current regimen. Recheck serum concentration (☐ trough ☐ peak ☐ random) on _____ (date/time).

☑ Change regimen to Vancomycin 1500mg Q6°

☑ Recheck serum concentration (☑ trough ☐ peak ☐ random) on 11/6/07 @ 0200 (date/time).

Other: Monitor Scr daily

Pharmacist _____ Pager ID _____ Date _____ Time _____

Co-signature (if applicable) Jul I. Cuy Pager ID 17168 Date 11/5/07 Time 0800

Time spent: _____ minutes

PHARMACOKINEVAL

OTE 800744 Rev. 9/03

"PRGRECRD"

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

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Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
		Nurse Case Manager Note:
11/5/07	1045	Pt SIP accident c cane falling on head. In-Tell-Stakes Ha NAD noted. Will follow clinical course. - Shannon B RN
11/5/07	0600	NSing Rn 97? 68-114 150/62 1492/13275 PE Eyes PERRL Ⓟ Cayl Ⓢ Sc Ⓚ Karen Lue Ⓑ LLE VID Ⓛ LE RLE cast C-collar in Pl P/P: sp MVC - skull fx no intracranial bleed - cont c-collar
11/5/07	1518	
11/5/07	1600	Ortho: I: Intubated, sedated O: R foot in splint, elevated 2-5 toe slow CR. warm skin color dark Dopplers @ DP. PT. S/P: percutaneous primary @ 1-5 toe fx. possible venous congestion - loosening splint - observation
11/5/07	1503	

prgrecrd1

OTE 700222 Rev. 9/06

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Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5078680

MRN: 002581962
Date Exam Completed: 11/06/2007 09:03
Last Update: 11/07/2007

Addendum Begins

Please note that the correct impression for this report is as follows:

1. No significant changes since the prior examination. Stable extra-axial collection at the vertex, skull fracture. 2. No new acute intracranial hemorrhage or infarcts.

Addendum Ends

EXAMINATION: BRAIN CT 11/06/07 09:03:00

ACCESSION NUMBER: 5078680

INDICATION: Trauma, altered mental status

COMPARISON: Head CT 11/02/2007 and 11/01/2007

TECHNIQUE: CT of the brain without intravenous contrast.

FINDINGS: There is no new extra-axial fluid collections nor clear signs of acute infarct. The CSF spaces are symmetric and unchanged. There is no herniation. Again seen is extensive left sided frontotemporal soft tissue swelling with gas, with underlying fracture is extends to the left frontal bone obliquely into the sagittal suture. The previously described extra axial fluid collection near the vertex is not significantly changed since the prior studies. There is a small amount of subarachnoid blood in the inter-peduncular cistern.

IMPRESSION:
1. No evidence of intracranial injury or fractures.

VOICE DICTATED BY: %full name%

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5078680

MRN: 002581962
Date Exam Completed: 11/06/2007 09:03
Last Update: 11/07/2007

History: sp mvc

Technologist: SHANNON MILLS
Interpreter 1: MARIA SPAMPINATO
Interpreter 2:
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: MARIA SPAMPINATO
Date Authenticated: 11/7/2007

MUSC
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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5077914

MRN: 002581962
Date Exam Completed: 11/06/2007 03:53
Last Update: 11/06/2007

EXAMINATION: CHEST 11/06/07 03:53:00

ACCESSION NUMBER: 5077914

INDICATION: 27 year old with open skull fracture and respiratory insufficiency

COMPARISON: 11/5/07

FINDINGS: AP portable view. Support line and tubes remain in satisfactory position. Mediastinal and hilar contours and cardiac silhouette are stable. Left basal atelectasis and small left pleural effusion, stable.

IMPRESSION: Left lower lobe atelectasis and small pleural effusion

VOICE DICTATED BY: Dr. JAMES RAVENEL

History: 27 year old with open skull fracture

Technologist: GAY MARTIN
Interpreter 1: JAMES RAVENEL
Interpreter 2:
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/6/2007

Transcribed by: Tech IntTalk

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Charleston, SC
843-792-2123
Radiology Report

Patient: **GOMEZ-FRAGOSO, HECTOR** **MRN: 002581962**
Procedure: DIAG CERVICAL SPINE 2 VIEWS AP/LAT
Accession #: 5080007
Date Exam Completed: 11/06/2007 22:24
Last Update: 11/07/2007

EXAMINATION: CERVICAL SPINE 11/06/07 22:24:00

ACCESSION NUMBER: 5080007

INDICATION: c spine clearance, altered mental status

COMPARISON: None.

FINDINGS: Lateral flexion/extension views of the cervical spine were obtained. The craniocervical junction is unremarkable. The vertebral bodies are of normal height and alignment with no evidence of fracture or dislocation. Disc spaces are well maintained. There is a normal cervical curvature. There is no abnormal cervical motion with flexion/extension. The paraspinal soft tissues are normal. Left parietal/temporal/frontal bone fracture. Endotracheal tube with distal tip not visualized.

IMPRESSION:

No cervical instability.

VOICE DICTATED BY: Dr. Madelene Lewis
I have reviewed the images and agree with the findings in this report.

History: for c spine clerance

Technologist: DAVID DECHANT
Interpreter 1: WILLIAM CONWAY

Proxy Signer:

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Printed: 01/07/2008 10:42 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CERVICAL SPINE 2 VIEWS AP/LAT
Accession #: 5080007

MRN: 002581962
Date Exam Completed: 11/06/2007 22:24
Last Update: 11/07/2007

Interpreter 2: MADELINE LEWIS
Interpreter 3:
Date Dictated:

Authenticating Radiologist: WILLIAM CONWAY
Date Authenticated: 11/7/2007

Transcribed by: Tech IntTalk

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Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: **GOMEZ-FRAGOSO, HECTOR** **MRN: 002581962**
Procedure: CT CHEST PULMONARY EMBOLUS STUDY
Accession #: 5078646
Date Exam Completed: 11/06/2007 09:01
Last Update: 11/06/2007

EXAMINATION: CT CHEST WITH IV CONTRAST 11/06/07 09:01:00

ACCESSION NUMBER: 5078646

INDICATION: Status post blunt force trauma to the head with open skull fracture, poor A-A gradient, runs of tachycardia

COMPARISON: Chest 11/1/7

TECHNIQUE: Multiple contiguous helical slices were obtained from the lung apices to the lung bases following IV administration of 100 cc of Omnipaque 350 without immediate adverse reaction. PE protocol was utilized.

FINDINGS: There is no evidence of pulmonary embolus or aortic dissection. Heart is normal in size with no pericardial fluid or thickening. There is no mediastinal or hilar lymphadenopathy. Endotracheal tube and enteric tube are in satisfactory position.

Moderate dependent atelectasis is present bilaterally. There is no evidence of pleural fluid or pneumothorax. There are scattered patchy ground glass opacities, most compatible with foci of atelectasis or resolving contusion.

There are no worrisome lytic or blastic lesions in the visualized osseous structures. Right midshaft clavicular fracture is present.

Limited evaluation of the upper abdomen is unremarkable.

IMPRESSION:

1. No evidence of pulmonary embolus.
2. Moderate dependent atelectasis bilaterally.

VOICE DICTATED BY: Dr. Rick Bonsall
I have reviewed the images and agree with the findings in this report.

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT CHEST PULMONARY EMBOLUS STUDY
Accession #: 5078646

MRN: 002581962
Date Exam Completed: 11/06/2007 09:01
Last Update: 11/06/2007

History: 27 yo hm sp blunt force trauma to the head with open skull fracture

Technologist: SHANNON MILLS
Interpreter 1: JAMES RAVENEL
Interpreter 2: RICHARD BONSALL
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/6/2007

* N R S R E C R D *

MUSC
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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 6 2007

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

APP = Assume Pain Present

1 2 3 4 5 6 7 8 9MM

TIME	TEMP	PULSE	SPON: VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN / SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL / EYES
08	37.5	65	—		125/55	91					96		0830 CTscan	0	3	5	B	B	5	T/2
09	37.4	80	—		118/64	84					96									
10	37.0	71	—		132/67	88					98		Rands							
11	37	91	6		152/76	99					100		Brandi							
12	37.5	70	—		132/70	92					96				4	6	4	6	5	T/2
13	37	82	3		146/76	99					100		Allen/Dilaudid Shot							
14	37.5	70	—		136/63	90					96		1330 Ativan	3	4	6	4	5	5	T/4
15	37	76	—		132/60	91					99									
16	37	71	—		125/67	87					96									
17	37	76	—		155/73	97					98		Family							
18	37.3	76	—		162/85	105					95				2	5	3	5	5	T/4
19	37.2	77	—		157/71	96					96									
20	37.2	70	—		135/59	79					94			0	3	5	2	B	5	T/4
21	37.1	67	—		145/62	84					99			0	3	5	2	B	5	T/3
22	37.3	61	—		150/63	84					99		Flex-ax							
23	37	59	—		145/57	87					99			0	3	5	2	B	5	T/2
24	37	56	—		117/58	76					100			0	3	5	2	B	5	T/2
01	37	58	—		141/62	78					98		Bath, Labs	0	3	5	2	B	5	T/2
02	37	64	—		164/74	89					100			0	3	5	2	B	5	T/2
03	37	68	—		151/61	87					100		CJ	0	3	5	2	B	5	T/2
04	36.9	67	1		144/71	85					100			0	3	5	2	B	5	T/2
05	37.4	86	—		172/74	89					100			0	3	5	2	B	5	T/2
06	37.3	70	—		134/66	89					97		prsc 1 of 2	0	3	5	2	B	5	T/2
07	37.3	68	—		149/69	91					99			0	3	5	2	B	5	T/2

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 0 2007

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
Suzanne Hartmann RN 19-0730	SH		

UP# 411230 rev 8/03

NRSRECRD

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 6 2007

page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08					146	
09					146	4330
10					229	559
11					351	910
12					354	1264
13					300	1564
14					414	1978
15					262	2240
16					214	2454
17					136	2590
18					136	2726
19					136	2862
20					386	3248
21					386	3634
22					285	3919
23					136	4055
24					137	4192
01					142	4334
02					380	4714
03					380	5094
04					136	5230
05					683	5913
06					133	6046
07					128	6174

UP# 411230 rev 8/03

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NOV 0 6 2007

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____
page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0715 Report received from night RN. Pt rested. Care to 0830. Pt to CT Scan to 0900. Pt returned from CT Scan. Pt well. To 0915. Complete bed bath & linen change done to 0930. See flow for assessment. VS, CBG & Vent Settings. Pt remains on BIPAP. Pt repositioned. Pressure pts to 3 last toes - leg elevated. Pt elevator. 02 sats 98% on RA. Pt to get up. All other toes purple. To 1000 Dr. Fulda rounds made to 1100 Dr. Long Fulda up to touch pt to 1300. Propofol & Fentanyl d/c'd. Ativan @ 2mg/hr & Dilaudid @ 2mg/hr started. To 1330 to Unit. To 1500 RN & RT to 1700 pt brother in to visit update given. To 1800 pt spontaneously moves BUE & BLE. 9 vascilex IS to 1500. To 1910 Report given to oncoming RN. Substitute RN

1930 Received report, assumed care of patient. Chart check, drip check and assessed patient & offgoing RN. Mouth care, eye care, foley care done. SH

2000 Patient assessment unchanged. SH

2200 Dr Krisha, XR PA & bedside for flex-ex films. Completed & incident. Miami-J pads rd, cleaned. SH

2300 Dr Hand notified of HR. SH

2000 Bath, labs, ABG. SH

345 Abs. gaze noted. CCMD + NSMD notified. Pt to CT. SH

350. Patient returned from CT. Tolerated transport. Results pending. SH

700 Report to oncoming RN. SH

UP# 411230 rev 8/03

* N R S R E C R D *

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NOV 0 6 2007

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seecy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	Q HRY	STOOL	EMESIS	OG/NG	RESID			
08		40	40							
09	80	80	80 / 120							
10	200	85	85 / 205							
11	345	140	140 / 345							
12	400	55	55 / 400							
13	455	55	55 / 455							
14	490	35	35 / 490							
15	540	50	50 / 540							
16	625	85	85 / 625							
17	675	50	50 / 675			350	350			
18	750	75	75 / 750							
19	1100		50 / 800							
20	1200	50	50 / 850							
21	1325	125	125 / 975							
22	1450	125	125 / 1100							
23	1525	75	75 / 1175							
24	1575	50	50 / 1225							
01	1625	50	50 / 1275							
02	1675	50	50 / 1325							
03										
04	1875	200	200 / 1525							
05	1950	75	75 / 1600							
06	2025	75	75 / 1675			150	500			
07	2075	50	50 / 1725							

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HECTOR
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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

SAFETY

- ☐ Hospital ID band on ☐ Allergy band on
- ☐ Call system accessible
- ☐ Bed in low position ☐ Bed brakes on ☐ Bed alarms on
- ☐ Bed heel pressure relief ☐ On ☐ Off reason: _____
- ☐ IV solutions verified
- ☐ IV tubing/bag dated
- ☐ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status ☐ Violent behavior
  - ☐ History of falls ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances ☐ Other _____

○ Any risk criteria identified, implement the **Safety** section of the **POC**.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose Sedated	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented orthostatic hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:				
TOTAL POINTS:		☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement **Safety** section of the **POC**.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE	NA				
A-LINE SITE CARE					
TRACH CARE	NA				
BATH	0930 TB				
FOLEY / PERI CARE	0930 TB				
FOLEY D/C'd	—				
STRAIGHT CATH	—				
LINEN CHANGE	0930 TB				
SKIN CARE	0930 TB				
PEG SITE CARE	NA				
TYPE OF DIET	NPO				
% EATEN	—				
PACING WIRES INSULATED SECURED	✓				
SPECIALTY BED	ICU				

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* N R S R E C R D *

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page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES			HEMATOLOGY				CHEMISTRY								
TYPE O, DEL	MODE	FiO2	PEEP	CPAP	MIN VENT		A-V	PO2	HCO3	HCT	WBC	PT	PLT	NA	CL	GLUC	CREAT	MG		FSBS	
	RATE	TV	PS	PIP			PH	PCO2	O2 SAT	HGB	RBC	PTT	INR	K	CO2	BUN	CA	PHOS			
V	PRVC	55	8																	101	08
	18	450	20																	183	09
																				104	10
																				82	11
							A	95	39												12
									95												13
																					14
																					15
																					16
																					17
V	PRVC	35	10																		18
	18	550		28	9.8																19
																					20
																					21
																					22
																					23
																					24
																					01
	650	46					A	7.44	46	24.9		157	1.2	139	119	68	0.7	2.6		72	02
									37	100				3.1	27	19	2%	0.5			
																					03
									21	87	17	203								107	04
									0.8	24	26	1.3								104	05
																					06
																				147	07

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page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/05

	Appearance	Location	Dressing	Calibrated Time	
A	S	(R) rad L rad	D I R I	0900	Rad. cath TBL IWF
P	S			2100	

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: PIV #16 Insert Date: 11 3 07

	Site	Appearance	Dressing	Blood Return
A	(R) upper arm LUE	S	D I D+I	NR NRS
P				

Line #2 Type: PIV #18 Insert Date: 11 5 07

	Site	Appearance	Dressing	Blood Return
A	(L) forearm LFA	S	D I D+I	NO NO
P		S		

Line #3 Type: PIV #18 Insert Date: 11 / 07

	Site	Appearance	Dressing	Blood Return
A	(R) upper arm RAA	S	D I D+I	NO NO
P		S		

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☑ A ☐ P **WNL:** *No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.*

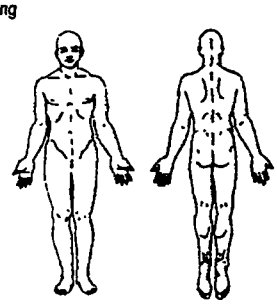
Abnormal Findings

☐ A ☐ P Nausea ☐ A ☐ P Itching ☐ A ☐ P Chills
☐ A ☐ P Fever ☐ A ☐ P Sweating ☐ A ☐ P *Difficulty sleeping*
☐ A ☐ P Pain ☐ A ☐ P Receiving analgesic therapy

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐ A ☐ P New ☐ A ☐ P Ongoing

Pain Description
☐ A ☐ P Dull ☐ A ☐ P Constant
☐ A ☐ P Burning ☐ A ☐ P Cramping
☐ A ☐ P Stabbing ☐ A ☐ P Radiating
☐ A ☐ P Throbbing ☐ A ☐ P Tingling



Location of pain (on the diagram, put an X on the area where the patient complains of pain)

○ Any problems identified, implement **Comfort** section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

- ☐ Psychosocial / Spiritual / Education A M P M
- ☐ Comfort A M P M
- ☐ Neurologic / EENT A M P M
- ☐ Safety A M P M
- ☐ Functional / Musculoskeletal A M P M
- ☐ Skin / Wound A M P M
- ☐ Cardiovascular A M P M
- ☐ Respiratory A M P M
- ☐ Gastrointestinal A M P M
- ☐ Genitourinary A M P M
- ☐ Nutrition A M P M
- ☐ Discharge Planning A _____ P _____
- ☐ Other _____ A _____ P _____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE TIME

PM SHIFT ASSESSMENT
SIGNATURE TIME

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NRSRECRD

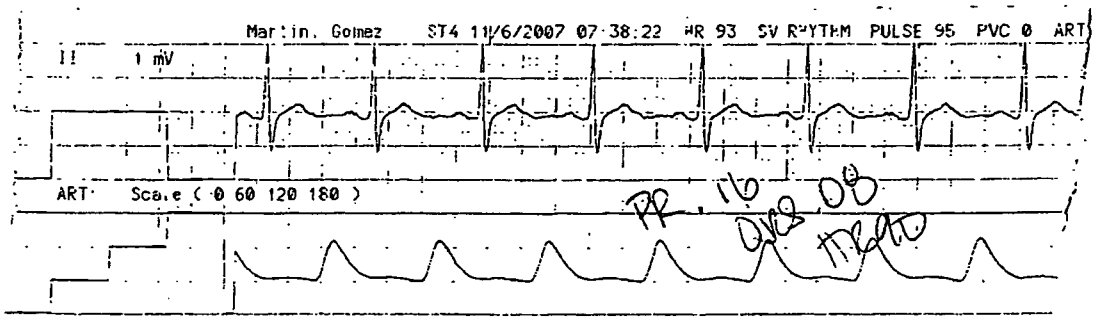
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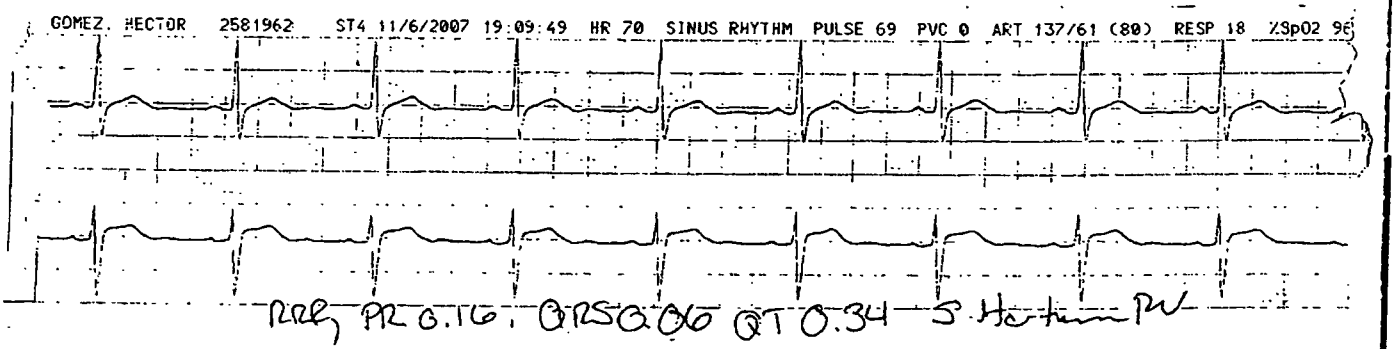
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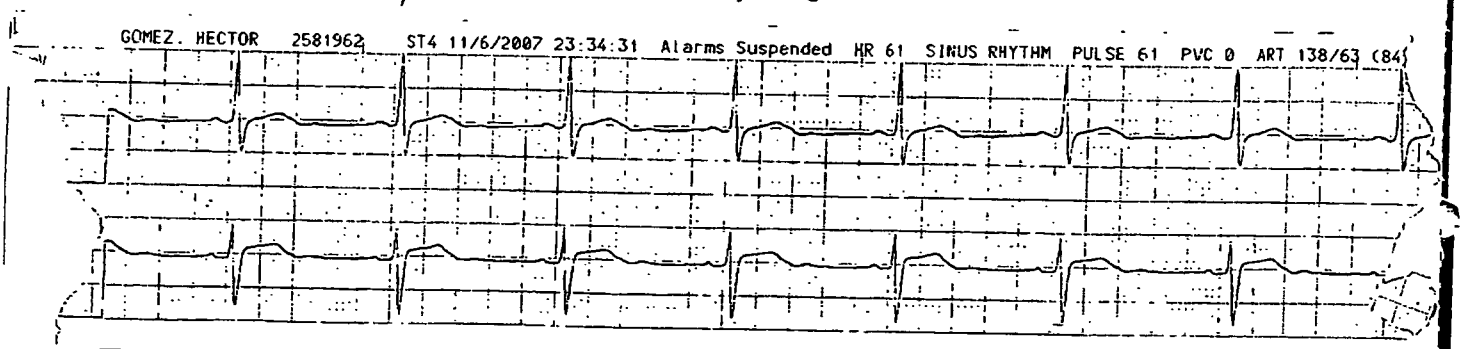
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page 5 of 12

THIS SPACE MONITOR STRIPS







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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 6 2007

page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM _____

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☑ A ☑ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location A	✓ / location P	Suction A	Suction P	Drainage A	Drainage P
NGT	Nasal	Nare	LC	C	BR	BR
OGT						
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

☐ Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P ***WNL:*** *Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.*
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☑ A ☑ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P Condom ☑ A ☑ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
☐ Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation

☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
☐ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
☐ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** *Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.*

Abnormal Findings

	R Arm A	R Arm P	L Arm A	L Arm P	R Leg A	R Leg P	L Leg A	L Leg P
Limited ROM								
Weakness								
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Size/Type
☑ A ☑ P SCD/foot pump LGE
☐ A ☐ P TED
☐ A ☐ P Traction
☑ A ☑ P Cast/splint R leg c pass vas dog x3
☐ A ☐ P External fixator
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ☑ A ☑ P Unable to verbalize EH
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☑ A ☑ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin impairments

Location

☐ A ☐ P Surgical incision _____
dressing type/appearance _____
☑ A ☑ P Drain fenrose to top head
☐ A ☐ P Drain _____
☑ A ☑ P Wound sutures of A tip fingers to top head
dressing type/appearance _____
☑ A ☑ P Other CALF on wedge
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

☒ Any problems identified implement **Skin/Wound** section of the **POC.**

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SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	00	02	04	06
Suction/cough / Secretions	TB	TB	TB	TB			SX		SX			
HOB>30 degrees unless contraindicated	TB	TB	TB	TB			✓	✓	✓	✓	✓	✓
A line site ✓	TB	TB	TB	TB			✓	✓	✓	✓	✓	✓
IV site ✓	TB	TB	TB	TB			✓	✓	✓	✓	✓	✓
Chest tube patent ✓	NA	→					NA					
NG/OG place ✓	TB	—	TB	—			✓			✓		✓
Mouth care	TB	TB	TB	TB			✓	✓	✓	✓	✓	✓
Turn / Passive ROM	TB	TB	TB	TB			✓ SH	✓	✓	✓	✓	✓
Side Rails	X3	X3	X3	X3			X3	✓	✓	✓	✓	✓
Incen. Spir./ deep breathe	Vent	Vent	Vent	Vent			Vent					
Alarms on / Assessment reviewed	TB	TB	TB	TB			SH	✓ SH	✓ SH	✓ SH	✓ SH	✓ SH

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 6 2007

page 7 of 12

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☑ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☐ A ☑ P Chemical paralysis/sedation propofol

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	1	2	1	1
P	1	2	1	1

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☑ A ☐ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☑ A ☐ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

☑ Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐ A ☐ P Arrhythmia _____

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	+1		+1		
P	+1		+1		

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	+2	+2	+2	+2	
P	+2	+2	+2	+2	

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate A	Rate V	mA A	mA V	Sensitivity A	Sensitivity V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

☑ Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☑ A ☐ P: Suction functioning

☑ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	R	R	R
P	R	R	R	R	R

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	7.0		25
P	ET	7.0	NA	25

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal A	Suction amt or H_2O Seal P	Drainage A	Drainage P	Air Leak A	Air Leak P	SQ emphysema A	SQ emphysema P

☑ Any problems identified, implement **Respiratory** section of the POC.

UP# 411230 rev 8/03

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SPENDO

SPENDO
BRONCHOSCOPY SERVICES
BRONCHOSCOPY REPORT
Page 1 of 1

STAMP PLATE AREA

P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name _____

MRN _____

Date: 11/01/07

Attending: Fields

Fellow:

Assistants: Rayon

Indications: pneumonia

Vital signs:	BP	P	SPO 2
Pre:	157/73	61	99
Post:	161/76	95	100

Scope ID No. 111025

TIME: Start 1100 Stop 1120

Pre-procedure:	Drug	Dose	Route
1.			
2.			
3.			

Medications

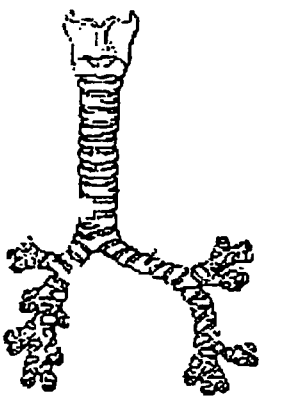
Procedure:	Drug	Dose	Route
1.			
2.	Ds. cursin / notes		
3.			

FINDINGS

Trachea/Carina clear

Supraglottic/Larynx

RIGHT SIDE	LEFT SIDE
RUL moderate secretions	LUL some mucus
RM moderate secretions	LINGULA
RLL moderate secretions	LLL copious mucus - inflamed/edematous airway



Specimens:	Location		Location
☐ Bronchial Wash		☐ TBBX	
☒ BAL	LLL	☐ Protected Brush	
☐ Brushings		☐ Needle Biopsy	
☐ Endo Biopsies		☐ Gold Probe/Laser	

POST PROCEDURE NOTE: no complications; secretions thru out - sample from LLL sent for CX

POST-BRONCH DIAGNOSIS: pneumonia

FINAL DIAGNOSIS: _____

Pulmonary Fellow/Date Byrd MD

Pulmonary Attending/Date Gary Fields

☒ I was present for the entire procedure.

BRONCHOREPORT1

OTE 800158 Rev. 10/02

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PRGRECRD

PRGRECRD
INTERDISCIPLINARY PROGRESS NOTES
PHARMACOKINETIC EVALUATION
(Page 1 of 2)

STAMP PLATE AREA

P490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M2581962

Patient Name Gomez, Hector
MRN 2581962

Evaluation requested by: STICU Service

Medication evaluated: Vancomycin

Comments (include current regimen and pertinent laboratory and clinical data):
26yo male w/skull fracture; meningitis prophylaxis Δ to VAP protocol. Want a vancomycin ~~peak~~ trough 15-20.
Also treating with tobramycin 300mg Q12° + meropenem 1gm Q8°. D/c Claforan.
WBC: 8.01 SCr: 0.8 T_{max}: 37.4

Wt (actual): 89.6 kg Ht: 64 in ~~cm~~ IBW: 59.2 kg Dosing wt 89.6 kg

Serum concentration (☐ trough ☐ peak ☑ random) drawn at 0300 (time) on 11/6/07 (date) reported as 13 mcg/mL (desired 15-20 mcg/mL).

Serum concentration (☐ trough ☐ peak ☐ random) drawn at _____ (time) on _____ (date) reported as _____ (desired _____).

Steady-state concentration? ☑ Yes ☐ No

Summary of dosing (if not steady-state):

Volume of distribution: ~~49.7~~ SCR 62.7 L/kg ☑ Calculated ☑ Estimated

Elimination rate (k_e): 0.173 hr^{-1}; **half-life:** 4hrs hr

Assessment: Trough not what was expected and <15mcg/mL due to increased (K_e) and a $t_{1/2} \approx$ 4hrs

Expected trough of 16.7mcg/mL with new dosing regimen

Recommendations:

☐ Continue current regimen. No further serum concentrations needed unless patient's condition changes.

☐ Continue current regimen. Recheck serum concentration (☐ trough ☐ peak ☐ random) on _____ (date/time).

☑ Change regimen to Vancomycin 1750mg Q6° starting 1400 on 11/6/07

☐ Recheck serum concentration (☑ trough ☐ peak ☐ random) on 0800 11/7 prior to 4th dose (date/time).

Other: monitor SCr; tobramycin trough; D/c Claforan.

Pharmacist [signature] Pager ID 3673 Date 11/7/07 Time 5 pm
Co-signature (if applicable) Joel C Key Pager ID 17169 Date 11/6/07 Time 5 pm
Time spent: _____ minutes

PHARMACOKINEVAL

OTE 800744 Rev. 9/03

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STA... PLATE AREA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

PRGRECRD
INTERDISCIPLINARY PROGRESS NOTES
PHARMACOKINETIC EVALUATION
(Page 1 of 2)

Patient Name Hector Gomez
MRN 2581962

Evaluation requested by: STICU Service

Medication evaluated: Tobramycin

Comments (include current regimen and pertinent laboratory and clinical data):
VAP ~~prophylaxis~~ empiric dosing: tobramycin 300mg Q12°; Vancomycin 1750mg Q6° · meropenam 1gm Q8°
· 27yo HM w/head injury on ventilator. meningitis prophylaxis originally ⇒ VAP protocol due to suspected bronchoscopy. Culture to follow
SCr: 0.8 WBC: 8 Tmax: 37.4°C est CrCl: 116 mL/min

Wt (actual): 89.6 kg Ht: 64" ~~cm~~ IBW: 59.2 kg Dosing wt: 71 kg

Serum concentration (☑ trough ☐ peak ☐ random) drawn at _____ (time) on _____ (date) reported as Initial Dose (desired < 1 mcg/mL).

Serum concentration (☐ trough ☑ peak ☐ random) drawn at _____ (time) on _____ (date) reported as Initial Dose (desired about 15 mcg/mL).

Steady-state concentration? ☑ Yes ☐ No

Summary of dosing (if not steady-state):

Volume of distribution: 17.75 L ~~L/kg~~ ☐ Calculated ☑ Estimated

Elimination rate (k_e): 0.2884 hr^{-1}; half-life: 2.4 hr

Assessment: 300mg Q12° will give an estimated trough < 1 mcg/mL based on estimated data above (V_d; $t_{1/2}$; k_e). Check cultures on 11/7/07 & trough as stated below. (trough < 1; peak ≈ 15 mcg/mL

Recommendations:

☐ Continue current regimen. No further serum concentrations needed unless patient's condition changes.

☐ Continue current regimen. Recheck serum concentration (☐ trough ☐ peak ☐ random) on _____ (date/time).

☐ Change regimen to _____

☑ Recheck serum concentration (☑ trough ☐ peak ☐ random) on 1800 (11/7/07) (date/time).

Other:

Pharmacist _____ Pager ID _____ Date 11/8/07 Time _____

Co-signature (if applicable) Jay C. Key PharmD student Pager ID 17168 Date 11/6/07 Time 5pm

Time spent: _____ minutes

PHARMACOKINEVAL

OTE 800744 Rev. 9/03

PRGRECRD

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/08

P:490943644 DOB:01/01/1951 L M
GOMEZ
Patient Nam HECTOR
MRN Adm:11/01/07 M:2581962

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 6 mg NOT: 6.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/8/07	0645	S/O issues overnight. Pt remains intubated + sedated not breathing over the vent. Pt remains on vent settings from yesterday + improvement of P_aO_2.
		1/90 37.2 86 18 134/56 95% PRVC 18/550/5/50%
		9659 || 3890 → 1150NG
		Gen: NAD, intubated/sedated & FC, non-oriented.
		HEENT: NG/ET in place
		Neck: Miami J in place
	1470	CV: RRR s m/r/g
		Lungs: CTAB, NVBS
		Abd: soft, nd, (+) bs (hyperactive)
		Extrem: R+E: 2+ → 1+ bilat + areas of discoloration/venous congestion questionable cap refill, free warm. Dopplerable DP and PT. Splint not tight / compartments soft.
		Labs 7.45/38/73/94.8 7.2 150/116/15/95
		Vanc trough - 13.0 8 Zos 2.9 30 0.8
		Serum drain culture - NBCs, GPCB, GNR 2+ 8.3 2.7 2.8
		A/P: 27 yo man s/p MVA accident.
		1. Resp - A/a gradient remains low and pt may misrepresent. resp cult/gram stain. Secretions are moderate. Given current state plan to get CTPE now for suspected PE.
		2. CV: (+) ICC, resp
		3. Endo - Na 150, K 2.9 - Given some replacement K overnight will re-V lytes this am.
		4. Heme - type + crossed for 2u / blood would not of blood. Will transfuse if <8gm.
		5. Ortho aware of toes.

Trevor Hatch MS4

prgrecrd1

OTE 700222 Rev. 9/08

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07

ATTENDING PHYSICIAN NOTE

MRN: 2581962

NAME: Gomez, Hector

Date: 11-6-07 Service: TCU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History: 27 y.o.

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to PRVC 580 18

Upon personally questioning the patient, I can confirm that the following are the key history factors: 55 8

Physical Examination: Pulse: 70 BP: 150/67 Resp Rate: 18 T: 99F Input: 4655 Output: 3820

7.45/38/73/

Neuro: sedated

Eyes:

ENT:

CV: RRR, (-)m

Resp: mostly clear (B)

GI/Nutr: soft, NB/NT, +BS

CU/Renal:

MuscSkel:

Skin: 2+ (B) DP pulses

Psych:

Other: (B) toes discolored

propofol @ 70
fentanyl @ 50

8 / 220
22.5

☒ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.

☐ I have reviewed the results radiographs as documented in the resident's note.

☒ I have personally reviewed pertinent X-ray examinations. → LLL consolidation

☐ I have personally reviewed the results of additional medical testing and monitor output.

☐ I have personally discussed the case with _____

Diagnoses/Problems

1. open skull fx — ☐New ☐Improved ☒ Unchanged ☐Worsening
2. Resp insufficiency — ☐New ☐Improved ☒ Unchanged ☐Worsening
3. Cervical + thoracic spinous process fx/transverse fx — ☐New ☐Improved ☒ Unchanged ☐Worsening
4. _____ — ☐New ☐Improved ☐ Unchanged ☐Worsening
5. _____ — ☐New ☐Improved ☐ Unchanged ☐Worsening
6. _____ — ☐New ☐Improved ☐ Unchanged ☐Worsening

Management Options/Recommendations

1.
2. BAL to clear / sample LLL
3. ~~Antibiotics~~ Watch W/H
4. Cont to titrate gtt prn RASS
5.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☒High

☒ Pt is critically ill/injured. I spent 30 minutes providing critical care to this patient.

Overall Condition: ☒Critical ☐Serious ☐Fair ☐Good

Signature _____ Date _____

UMA #19100-13 revised 11/06

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Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5080052

MRN: 002581962
Date Exam Completed: 11/07/2007 04:43
Last Update: 11/07/2007

EXAMINATION: PORTABLE CHEST 11/07/07 04:43:00

ACCESSION NUMBER: 5080052

INDICATION: STATUS POST TRAUMA TO HEAD, FAILED EXTUBATION TIMES 2, HIGH OXYGEN REQUIREMENT

COMPARISON: CXR 11/6/07

FINDINGS: SINGLE FRONTAL RADIOGRAPH OF THe chest demonstrates unchanged position of endotracheal tube and enteric tube. Stable size and contour of the cardiomediastinal silhouette. Hila and lungs demonstrate left basilar subsegmental atelectasis and effusion. Visualized portions of the bony thorax are unremarkable.

IMPRESSION:

1. Left basilar subsegmental atelectasis and small left effusion.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW
I have reviewed the images and agree with the findings in this report.

History: S/P trauma to head, failed extubation x2, high oxygen requirement

Technologist: ELMON WATSON
Interpreter 1: PHILIP COSTELLO

Proxy Signer:

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:41 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5080052

MRN: 002581962
Date Exam Completed: 11/07/2007 04:43
Last Update: 11/07/2007

Interpreter 2: MARQUES BRADSHAW
Interpreter 3:
Date Dictated:

Authenticating Radiologist: PHILIP COSTELLO
Date Authenticated: 11/7/2007

Transcribed by: Tech IntTalk

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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5080006

MRN: 002581962
Date Exam Completed: 11/07/2007 03:50
Last Update: 11/08/2007

EXAMINATION: CT BRAIN 11/07/07 03:50:00

ACCESSION NUMBER: 5080006

INDICATION: Closed head injury with altered mental status

COMPARISON: CT brain 11/6/07

TECHNIQUE: Multiple contiguous 5 mm axial CT images were obtained through the brain without IV contrast. Coronal and sagittal reconstructions were also performed.

FINDINGS: There is no evidence for new extra-axial collection, and the previously seen collection adjacent to the vertex is unchanged. Extensive left-sided frontotemporal soft tissue swelling is again noted along the fracture of the left frontal bone extending to the sagittal suture, unchanged. There are no signs of acute infarction. The CSF spaces are symmetrical, without evidence for herniation. The small amount of blood seen near the interpedicular cisterns is poorly seen on today's study. There is no evidence for new hemorrhages. Gas fluid levels are again seen in bilateral paranasal sinuses.

IMPRESSION:

1. Stable examination without evidence for acute interval findings.

VOICE DICTATED BY: Dr. Matt Murray
I have reviewed the images and agree with the findings in this report.

History: s/p CHI

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Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: CT HEAD/BRAIN W/O CONTRAST
Accession #: 5080006

MRN: 002581962
Date Exam Completed: 11/07/2007 03:50
Last Update: 11/08/2007

Technologist: HAYLEY KOUROFFKY
Interpreter 1: M, MATHEUS
Interpreter 2: MATTHEW MURRAY
Interpreter 3: JOSH MCCAIN
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: M, MATHEUS
Date Authenticated: 11/8/2007

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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5081219

MRN: 002581962
Date Exam Completed: 11/07/2007 16:02
Last Update: 11/07/2007

EXAMINATION: PORTABLE CHEST 11/07/07 16:02:00

ACCESSION NUMBER: 5081219

INDICATION: CRUSH INJURY, DECREASED OXYGEN SATURATION

COMPARISON: CXR 11/7/07

FINDINGS: Single frontal radiograph of the chest demonstrates unchanged positon of endotracheal tube and enteric tube. New left central venous cather with tip overlying the superior vena cava. Stable size and contour of the cardiomediastinal silhouette. Hila and lungs demonstrate segmental atelectasis of the right upper lobe and lobar atelectasis of the left lower lobe. Ther is no evidence of pneumothorax. Visualized portions of the bony thorax are unchanged.

IMPRESSION:

1. Segmental atelectasis of the right upper lobe and lobar atelectasis of the left lower lobe.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW
I have reviewed the images and agree with the findings in this report.

History: crushin injury

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5081219

MRN: 002581962
Date Exam Completed: 11/07/2007 16:02
Last Update: 11/07/2007

Technologist: JANET WILSON
Interpreter 1: PHILIP COSTELLO
Interpreter 2: MARQUES BRADSHAW
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: PHILIP COSTELLO
Date Authenticated: 11/7/2007

Transcribed by: Tech IntTalk

* N R S R E C R D *

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 7 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

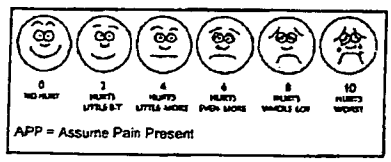
VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #



1 2 3 4 5 6 7 8 9MM

TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / ROMP	CVP	PA	CO / CI	SVR	S.O.	ICP / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN / SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL	EYES
08	37	72	18		142/64	85					99		PERRL	0	3	3	B	B	5	T	4
09	37.4	107	18		142/68	90					100		Lasix								
10	37.4	95	14		134/72	94					98		Rounds w/ Critical Attn								
11	37.4	82	18		132/70	90					95										
12	37.5	85	18		120/70	86					95		Dr. Wolfe		3	3	B	B	5	T	2
13	37.5	88	0 18		136/70	92					94										
14	37.4	89	18		150/70	94					95										
15	36.6	84	4 18		153/69	93					92		QLC placed/PPD								
16	37.1	114	18		140/62	88					95		PPD/PCXR/PBMX		3	3	B	B	5	T	2
17	36.5	105	18		123/70	78					92		Culture								
18	38.1	103	0 18		137/64						91										
19	38.0	114	0 18	109/68	125/69	88					90										
20	38.4	110	0 18		140/86	105	13				96		Peak flow ✗								
21	38.3	113	0 18	135/76	143/86	94	9				95		Heat pack toes	0	3	2	B	2	B	5	T	2
22	38.7	110	0 18		137/71	80	11				95										
23	38.5	108	0 18		135/71	83	9				93										
24	38.5	106	0 18		138/69	64	9				93		Heat Pack toes	0	3	3	B	3	B	5	T	2
01	38.4	101	0 18		129/64	71	6				93										
02	38.4	102	0 18		123/62	77	6				93		LABS, ABG								
03	38.5	95	18		128/64	78	6				93		CXR								
04	38.5	107	18		134/63	81	6				93			0	3	3	B	3	B	5	T	2
05	38.5	100	18		124/60	77	8				92		Bath, Mian J 42 ABG								
06	38.5	97	18		122/60	75	6				94		toes warmer								
07	38.6	97	18		121/60	75	8				95										

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 7 2007

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
[signature]	[initials]		
Suzanne Hartmann TW 19-730	SH		

UP# 411230 rev 8/03

NRSRECRD

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 7 2007

page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	NS 20cc	Insulin 250units/250ml	Hydromorphone 50mg/100ml	Nexium 40mg/40ml	Meds	I Tube	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	PO	TUBE	INTAKE TOTALS HRLY TOTAL	CUM TOTAL
08	15	1.7	—	—		3	PRBC 300				409	
09	—	1.7			500	36					253	662
10	—	1.2	1	4 2 2	500	39					259	921
11	125 250	1.2	2	6 1 3		3 01					131	1052
12	10 260	1.1	2	8 1 4		3 15					116	1089
13	10 270	1.1	2	10 1 5		3 18					116	1104
14	—	1.1 2.1	2	12 1 6	50 350	321		Promote	80		57	1161
15	10 280	1.1 4.2	2	14 1 7		3 24				20 20	37	1198
16	10 290	1.3 4.5	2	16 1 8		3 27				20 60	36	1234
17	10 300	1.5 5.2	2	18 1 9	50 800	330				20 60	87	1321
18	10 310	1.6 7.1	2	20 1 10	100 900	333				20 100	28	1349
19	10 320	1.6 8.7	2	22 1 11		336				20 60	30	1379
20	10 330	10.4 9.1	2	24 1 12	100 800	339			30 30	40 160	187	1684
21	10 340	0.9 10	2	26 1 13		342				40 200	57	1741
22	10 350	1.7 11.7	2	28 1 14		345				40 240	58	1799
23	10 360	2.4 14.1	2	30 1 15		348				40 280	58	1857
24	10 370	3.2 17.3	2	32 1 16		348				40 320	59	1916
01	10 380	3.6 20.9	2	34 1 17		351				40 360	58	1974
02	10 390	1.9 22.8	2	36 1 18		354			30 60	40 400	58	2032
03	10 400	2.5 25.3	2	38 1 19		357				60 460	78	2110
04	10 410	4.09 29.4	2	40 1 20		360				60 520	80	2190
05	10 420	5.1 34.5	2	42 1 21		363				60 580	81	2271
06	10 430	3.5 38.4	2	44 1 22		366				60 640	80	2351
07	10 440	3.4 41.8	2	46 1 23		369				60 700	79	2430

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PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0715 Report received from night RN, Pt cont'd done TB 0900 Shadow for assessment, VS q4h & prn Dettrp. Prep VS PEARL pt. Spontaneously moves all extrems. opens eyes. Diaudid & Ativan gtt off x 45 min. (R) leg elevated on foot elevator. (+) pulses. Cold visible to great toe & 2. other 4 toes pink & cap refill noted. Q Remains on ventilator & PRBC 2nd unit started TB 0935 Lasix 20mg IV administered. Pt to be moved to dry place new A-line TB 1000 Rounds made. Diaudid 1mg/hr & Ativan 1 mg/hr TB 1200 Dr Wolfe in to see pt MS used oppay 4cc lidocaine to (R) foot foley TB 1330 Dentrx 1515 1445 Dr. in to place CVC d/c'd & pt to OR @ bedside TB 1515 Dr Stokes aware of ABG results. PEEP 15 1550 Pt temp spike 39° Hr 120's BP 180/75. Dr Stokes @ bedside 1610 PEEP 10, FiO2 TB 1600 Comfort pad foam & Pam & done TB 1700 all IV tubing changed TB 1745 Pt brother in to visit, update given 1910 Pt report given to Nancy RN

Jeb

1930 Recieved report. Chart check, drip check, nursing assessment completed. Tobramycin peak sent. SH
2125 Assessment unchanged. SH 2200 Assessment unchanged. SH
0000 Assessment unchanged. SH 0400 Both, linn D, miami-T pads cleaned, changed. 0600 ortho reeds SH

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24 HOUR CRITICAL CARE PATIENT RECORD

NOV 0 7 2007
Date _____

page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

TIME	OUTPUT CUM	OUTPUT HOURLY	URINE (Foley)	GASTRIC STOOL	GASTRIC EMESIS	GASTRIC OG/NG	GASTRIC RESID	CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
08		125	125							
09	275	150	150							
10	700	425	425							
11	2000	1300	1100							
12	2225	225	225							
13	2535	310	210			100				
14	2660	125	105							
15	2850	190	150							
16	2925	75	75							
17	3085	160	100							
18	3175	90	90							
19	3575	400	400							
20	4275	700	700				0			
21	4325	50	50							
22	4425	100	100							
23	4500	75	75							
24	4600	100	100							
01	4900	300	300							
02	5350	450	450				0			
03	5450	100	100							
04		100	100							
05	5600	50	50							
06	5775	175	175							
07	5950	175	175							

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NOV 07 2007

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 10 of 12

SAFETY

- ☑ Hospital ID band on ☐ Allergy band on
- ☐ Call system accessible
- ☐ Bed in low position ☑ Bed brakes on ☐ Bed alarms on
- ☐ Bed heel pressure relief ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status ☐ Violent behavior
  - ☐ History of falls ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances ☐ Other _____
- ○ Any risk criteria identified, implement the **Safety** section of the **POC**.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:	4			
TOTAL POINTS:		☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement **Safety** section of the **POC**.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION	0600				
IV SITE CARE LOCATION					
IV TUBING CHANGE	1600				
PICC LIMB CIRCUMFERENCE	NA				
A-LINE SITE CARE					
TRACH CARE					
BATH	1600 TB				
FOLEY / PERI CARE	1600 TB				
FOLEY D/C'd	✓				
STRAIGHT CATH	✓				
LINEN CHANGE	1600 TB				
SKIN CARE	1600 TB				
PEG SITE CARE	NA				
TYPE OF DIET	T.F				
% EATEN	✓				
PACING WIRES INSULATED SECURED	✓				
SPECIALTY BED	ICU				

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 07 2007

page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermicient Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES			HEMATOLOGY				CHEMISTRY							
TYPE O_2 DEL	MODE RATE	FIO_2 TV	PEEP PS	CPAP PIP	M.N VENT		A/V PH	PO_2 PCO_2	HCO_3 O_2SAT	HCT HGB	WBC RBC	PT PTT	IPLT INR	NA K	CL CO	GLUC BUN	CREAT CA	MG PHOS	FSBS	
V	PRVC 13	50	5																88	08
																			94	09
																			83	10
																			88	11
																			88	12
																			93	13
																			113	14
																				15
1610 1650	60	8																	90	16
	70	10																	112	17
	50																		113	18
																			88	19
																			80	20
																			103	21
																			116	22
																			120	23
																			134	24
																				01
							7.44	71 44	29 92		16.3 28.2		13	141 35	19 30	98 21	1 8.6	2.3 4.5	92	02
V	PRVC 16	40	5	10															110	03
																			129	04
							7.44	43	29.1 93										137	05
																			131	06
																			105	07

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page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/6/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	Radial	D,I	0900	0d. 10A
P	S	L radial	D+I	2100	+BL +WF

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: PIV #18 Insert Date: 11/5/07

	Site	Appearance	Dressing	Blood Return
A	(L) forearm	S	D,I	N
P	L EA	S	D+I	N

Line #2 Type: PIV #19 Insert Date: 11/5/07

	Site	Appearance	Dressing	Blood Return
A	(R) forearm	S	D,I	N
P	R am	S	D+I	N

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

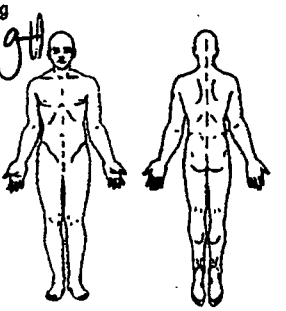
Abnormal Findings

☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☑P Receiving analgesic therapy Dilaudid gtt
(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description ☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



☑ Any problems identified, implement Comfort section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation

R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

☐ Psychosocial / Spiritual / Education A_____ P_____
☐ Comfort A M P M
☑ Neurologic / EENT A M P M
☐ Safety A M P M
☐ Functional / Musculoskeletal A M P M
☐ Skin / Wound A M P M
☐ Cardiovascular A M P M
☐ Respiratory A M P M
☐ Gastrointestinal A M P M
☐ Genitourinary A M P M
☐ Nutrition A M P M
☐ Discharge Planning A_____ P_____
☐ Other _____ A_____ P_____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE TIME 0800

PM SHIFT ASSESSMENT
Suzanne Hartmann 2000
SIGNATURE TIME

UP# 411230 rev 8/03

* N R S R E C R D *

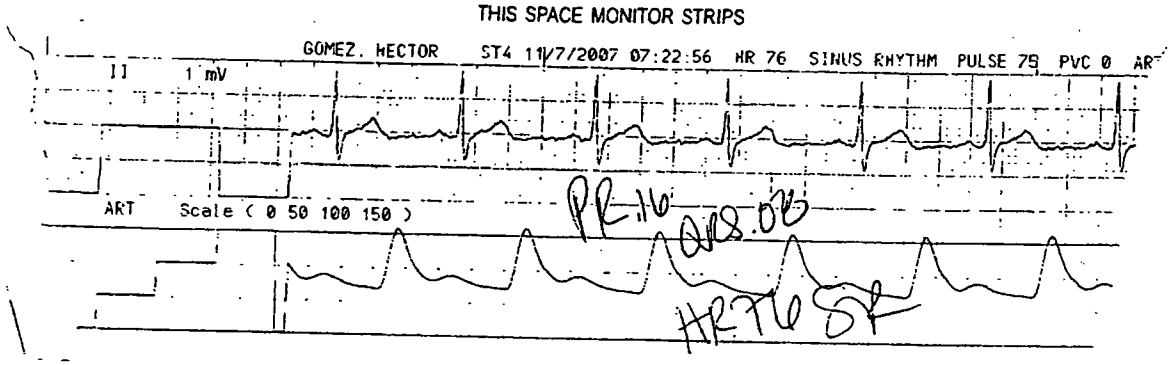
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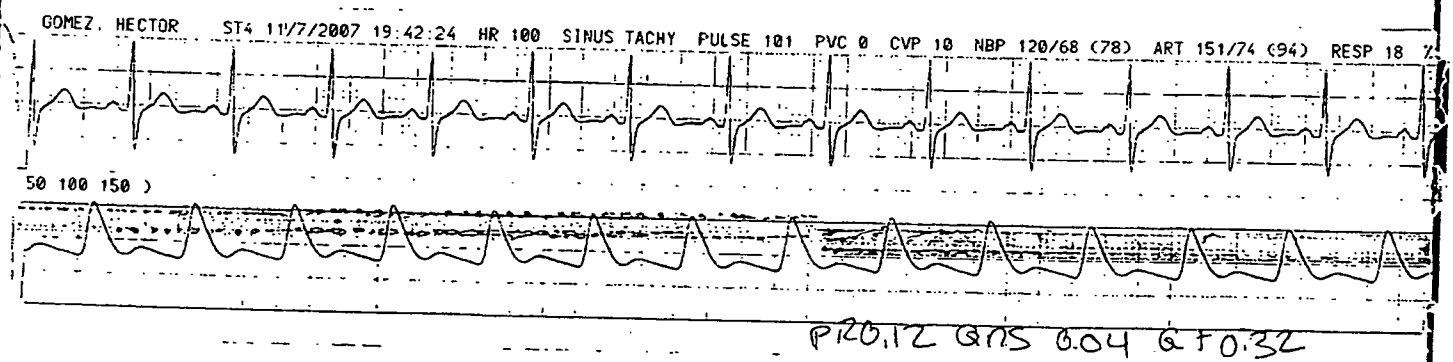
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page 5 of 12

THIS SPACE MONITOR STRIPS





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page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM _____

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location A	✓ / location P	Suction A	Suction P	Drainage A	Drainage P
NGT	✓ (illegible)	✓ ov	(illegible)			
OGT						
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

✓ Any problems identified, implement **Gastrointestinal** section of the **POC**.

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☑ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P Condom ☑ A ☑ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
✓ Any problems identified, implement **Genitourinary** section of the **POC**.

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm A	R Arm P	L Arm A	L Arm P	R Leg A	R Leg P	L Leg A	L Leg P
Limited ROM					✓ X			
Weakness								
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Site / Type
☐ A ☑ P SCD/foot pump (illegible)
☐ A ☐ P TED
☐ A ☐ P Traction
☐ A ☑ P Cast/splint BKA cast elevator
☐ A ☑ P External fixator Pins (R) 3 sites
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ☐ A ☑ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
✓ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC**.

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin impairments

Location

☐ A ☐ P Surgical incision _____
dressing type/appearance
☐ A ☑ P Drain Penrose L Thigh
☐ A ☐ P Drain _____
☐ A ☐ P Wound _____
dressing type/appearance
☐ A ☑ P Other Sutures of L Thigh wound
☐ A ☐ P Other _____
Wound vac™

	Location	mmHg	Suction
A			
P			

✓ Any problems identified implement **Skin/Wound** section of the **POC**.

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SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	00	02	04	06
Suction/cough / Secretions	B mod th	B	B th	B	B mod th	B	Sx mod		Sx	Sx		
HOB>30 degrees unless contraindicated	TB	TB	TB	TB	TB	TB	✓	✓	✓	✓	✓	✓
A line site ✓	TB	TB	TB	TB	TB	TB	✓	✓	✓	✓	✓	✓
IV site ✓	B	B	B	B	B		✓	✓	✓	✓	✓	✓
Chest tube patent ✓	NA	—	—	—	—	—	NA	—	—	—	—	—
NG/OG place ✓	TB	—	TB	—	TB	—	✓	✓	✓	✓	✓	✓
Mouth care	TB	TB	TB	TB	TB	TB	✓	✓	✓	✓	✓	✓
Turn / Passive ROM	B	B	B	B	B	B	✓	✓	✓	✓	✓	✓
Side Rails	X3	X3	X3	X3	X3	X3	X3	✓	✓	✓	✓	✓
Incen. Spir./ deep breathe	Vent	Vent	Vent	Vent	Vent	Vent	Vent	✓	✓	✓	✓	✓
Alarms on / Assessment reviewed	B	B	B	B	B	B	✓ SM	✓	✓	✓	✓	✓

UP# 411230 rev 8/03

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 07 2007

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☐ A ☐ P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	0	0	0	0
P	2	2	2	2

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☐ A ☑ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☐ A ☐ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

☑ Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐ A ☐ P Arrhythmia _____

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	+1	+1	+1	+1	
P	+1	+1	+1	+1	

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	+2	+2	+2	+2	
P	+2	+2	+2	+2	

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

☑ Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☑ A ☐ P: Suction functioning

☑ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	D	R	D
P	R	R	D	R	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	7.0		24
P	ETT	7.0		24

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☑ Any problems identified, implement **Respiratory** section of the POC.

"PRC"

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

CENTRAL VENOUS CATHETER PROCEDURE NOTE & CHECKLIST: CRITICAL CARE SERVICES

Page 1 of 1

Form Origination Date: 1/00
Version: 3
Version Date: 6/07

Patient Name _____
MRN _____
STAMP PLATE / PATIENT IDENTIFICATION LABEL

Date / Time of procedure start: ~~1745~~ 11/7 @ 1445 ☒ Time out performed prior to procedure

Steps: ☒ Hand hygiene prior to donning gloves
☒ Maximum barrier precautions used: hat, mask, sterile gloves, full sterile body drape
☒ Cleansed skin with chlorhexidine **(Avoid femoral site for access if possible)**

Above steps were followed? ☒ Yes (sign below as observer) ☐ No **Catheter needs to be replaced within 24 hours**

Was this a clinical emergency? ☐ Yes ☒ No

Observer's Signature: _____
(typically the RN, but may include other licensed providers)

Site identified prior to vein puncture ☐ with ultrasound or ☒ by landmark
☐ Real-time ultrasound guidance was used during vein puncture.
Lumen number on central venous catheter inserted: ☐ 1 ☐ 2 ☐ 3 ☒ 4
Introducer? ☒ Yes ☐ No
Location: ☒ Left ☐ Right Subclavian vein. ☒ 1% lidocaine local anesthesia was used.

Check technique:

☐ Over a wire. The tip of the old catheter was sent for culture. ☐ Yes ☐ No
☒ New stick (Seldinger technique)

At the completion of the procedure: Blood return in all lumens ☒ Yes ☐ No Procedure complications ☐ Yes ☒ No Biopatch applied ☒ Yes ☐ No Sterile dressing applied ☒ Yes ☐ No	Time procedure completed: 1515 Describe procedure complications here:
Additional Comments:	
Signature of Physician performing procedure: _____ Pager ID 15325 Date 11/7 Time 1520 AM/PM	
My signature below certifies that I ☒ was ☐ was not (check one) present and personally supervising the performance of this entire procedure. (Lack of signature does not imply lack of proper supervision. This relates only to attending physician presence for the entire procedure as defined under the CMS regulations for supervision by teaching physicians.)	

I certify that this person ☐ is ☒ is not (check one) qualified to perform this procedure unsupervised.

Attending Physician Signature _____ Date 11-7-07 Time 1500 AM/PM
centvencath

OTE 900357 Rev. 6/07

Observer: Use the term BREAK SCRUB to call attention to the fact that one of the steps (hand hygiene, maximum barrier precautions, site cleansing) was not completed appropriately. **This signifies to the physician the procedure must be restarted.**

PRGRECRD

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INTERDISCIPLINARY PROGRESS NOTES

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962
PLATE AREA

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/7/07	0415	MSVRC Ø acute events VS -37, 97, 18, 66/22 100% PRVC, 18, 35%, 650 6 OTE sedated / intubated CNS RRR 4/sm/2000 Resp b/l chest rise Abd soft NTND GNS - ↓2 V/Ø MS Extremities b/l UE middle drawn b/l LE PSRL AM. MRI c CBC/coag fx. Ø √ CT head from this AM. Admit flex/ext c spine Wounds. Cont to follow Keith 1530

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OTE 700222 Rev. 9/06

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Nam
MRN

STAMP PLATE AREA

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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

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USE: 0.5mg Not: .5 mg

Date	Time	
11/7/07	6 10 AM	ortho µ acute events 37° 70 134/66 18 97% intubated sedated, nonresponsive RLE: strong DP pulse toes 2-5 remain blue, demarcation unchanged pins intact A/P s/p percutaneous pinning of ⑤ 1-5 toe fx - venous congestion likely is ischemic origin but arterial supply to foot present & good DP/PT - cont to observe, loosened splint yesterday - will discuss Dr. Woolfe Amy Salamo 15268

prgrecrd1

OTE 700222 Rev. 9/06

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
Patient Name HECTOR
MRN Adm:11/01/07 M:2581962
[illegible] PLATE AREA

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	STICU
11/7/01	0645	Pt had another head CT overnight following development of disconjugate eye movements. FiO2 was decreased to 50%. Ativan & neuro exam
		Transfused 2 U PRBCs for Hct of 6.9: 7.44/37/146/24.9
		373 37 68 18 150/80 98% 149 119 119 60 6.0
		5843 | 2025 +500 Nl 3.1 27 16.7 8.7 223 221
Ativan 2 @ 12		Awake NAD, intubated, sedated @ FC
Morphine 6		HEENT: ET/NG in place. Corneals discordant gaze
		Pupils 3→2
Versed 1500		Neck: Marsh in place
Levemir		Lungs: Coarse BS throughout - some transmitted upper airway sounds
Pepcid		@ Base PRVC 550/18/≤/50%
Morphine		CV: distant HS, difficult to auscultate over vent. S, heard.
Keppra		& audible murmurs.
Ativan		Abd: soft NT NBS @ hs.
Dilaudid 2 mg		Gen: Edema in place.
		Ext: [illegible] warm + connected / cooler from surrounding [illegible]
		good DP + PT, cap refill not evident.
		A/P: 27 y/o hm S/P above accident, BFT to head c open skull fx.
		1. Resp - cont to wean FiO2 today. Will T/c on resp BAL, no
		results currently. Pt continues to slowly improve.
		2. Neuro - Head CT this am. Neuro Ex consistent c above.
		Will hold sedation for now.
		3. Heme: 1/2 PRBCs going now. Will follow. Hct if is decided that
		pt has head injury will check for H+H of 10/30.
		4. ID: On Vanc, Zosyn, meropenem for VAP suspected. Will T/c on
		cultures. Will consolidate Abx if necessary given volume [illegible]
		MSY

prgrecrd1

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"PRGRECRD"

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

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Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/1		NSURG PA
0700		Flex + Extension C-spine films without gross instability though plain radiographs incomplete with poor visualization of C6-T1. Head CT scan pending. Please call when patient gets to the floor and we will repeat flex-ext C-spine xrays in sitting position. Case Manager notified.
11/2/07	640AM	ORTHO MSH RECOM No acute events

prgrecrd1

OTE 700222 Rev. 9/06

"PRGRECRD"

MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR

INTERDISCIPLINARY PROGRESS NOTES

ATTENDING PHYSICIAN NOTE

MRN: 2581962

NAME: Gomez, Hector

Date: 11-7-07 Service: TCU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to PRVC 50 5 18 550 PP 28

Upon personally questioning the patient, I can confirm that the following are the key history factors: 7.44/37/146/24.9

Physical Examination: Pulse: 11 BP: 18 Resp Rate: 150/88 T: m 37.3 Input: 5443 Output: 2025

Neuro: sedated

Eyes: Ativan @ 2

ENT:

CV: RRR, distant Diluadid @ 2

Resp: coarse @

GI/Nutr: soft, ND, NT, +BS

CU/Renal:

MuscSkel:

Skin: 2+ B/LE pulses 8.7 21

Psych:

Other: @ toes discolored Cr 0.7 ↓ 0.6 ↑ 0.7 2u PRBCs

☑ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.

☐ I have reviewed the results radiographs as documented in the resident's note.

☑ I have personally reviewed pertinent X-ray examinations.

☐ I have personally reviewed the results of additional medical testing and monitor output.

☐ I have personally discussed the case with _____

Diagnoses/Problems

1. Resp Insuff ☐New ☐Improved ☑Unchanged ☐Worsening
2. Biliary Colitis negative cholangiogram ☐New ☐Improved ☑Unchanged ☐Worsening
3. open L skull FX ☐New ☐Improved ☑Unchanged ☐Worsening
4. cervical thoracic spinal fractures ☐New ☐Improved ☐Unchanged ☐Worsening
5. _____ ☐New ☐Improved ☐Unchanged ☐Worsening
6. _____ ☐New ☐Improved ☐Unchanged ☐Worsening

Management Options/Recommendations

1. Lasix challenge Start TFs
2. ↓ Ativan ↓ Dilaudid
3. DIC Vime
4. May be able to ↓ to PSV
5. _____
6. _____

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☑High

☑ Pt is critically ill/injured. I spent 30 minutes providing critical care to this patient.

Overall Condition: ☑Critical ☐Serious ☐Fair ☐Good

Tracy Field Signature Date _____

UMA #19100-13 revised 11/06

"PRGRECRD"

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

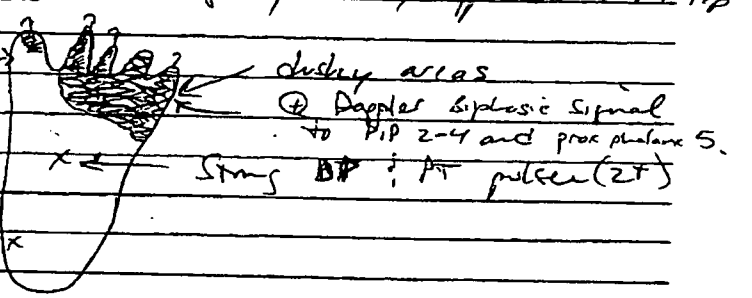
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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

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Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/7/7	1230 PM	ORTHO - Staff

Remains Intubated & Sedated.
- (R) LE in splint
- Toes 2-5 ē dusky but warm
- Great Toe warm ē slightly dusky appearance at tip



Splint loosened, compartments of foot/leg are soft.
Digital Block of 2-4 at MTP joints done
Sterilely ē 1% plain Lidocaine to ↓ vasospasm.

A/P CRANIAL Fx's ē Head injury, Resp failure,
(R) foot crush injury ē Fx's of all toes,
post traumatic vasospasm.
- Keep Toes at least level or above and keep warm.
- follow block to assess ↓ of vasospasm
- Allow tissue to declare ē prevent infxn of wounds or cellulitis

prgrecrd1

OTE 700222 Rev. 9/06

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5081109

MRN: 002581962
Date Exam Completed: 11/08/2007 04:17
Last Update: 11/08/2007

Chest

Accession Number: 5081109

Indication: 27 yo hm sp crane accident with open skull fracture

Comparison: 11 07 07

Findings: Single frontal radiograph of the chest demonstrates unchanged position endotracheal tube tip well above carina , left central venous catheter tip over superior vena cava nasogastric tube over stomach unchanged since prior exam . The size and contour of the cardiomediastinal silhouette and hilum are unchanged . Lungs again demonstrate air space opacity worse in the left lower lung and right upper lung apparent collapse in left lower lobe improves from prior film but no pneumothoraxis visible .

Impression:
No significant interval change.

History: 27 yo hm sp crane accident with open skull fracture

Technologist: LORI RAGER
Interpreter 1: STEPHEN SCHABEL
Interpreter 2:
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: STEPHEN SCHABEL
Date Authenticated: 11/8/2007

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:41 AM
Printed by: LINCOLN, COURTNEY

NRSRECRD

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

APP = Assume Pain Present

1 2 3 4 5 6 7 8 SMM

TIME	TEMP	PULSE	SPO2 / VENT RESP	CUFF BP	A-LINE BP	MAP / POWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL EYES
08	38.6	107	/15		114/57	72	5				93			C 3	4	4	B	B	5	ET 2
09	38.1	101	/18		150/71	79	6				94									
10	39.3	111	/18		125/62	82	8				92		1040: Tylenol PRN given							
11		110	/18		117/57	72	6				92									
12		103	/18		112/55	71	6				92		OG Inserted	0 3	4	4	B	B	5	ET 2
13	39.2	92	/18		124/61	76	6				95									
14		86	/18		127/65	80	6				98									
15	38.3	82	/18		133/68	83	6				97									
16	37.8	85	/18		145/77	96	4				97			0 3	4	4	B	B	5	ET 2
17	37.5	85	/18		139/77	98	3				96		Family Present							
18	37.3	90	/18		140/78	99	3				95									
19	37.3	90	/18		144/76	93	3				96									
20	37.4	103	—/18		145/78	98	4				96			0 3	4	4	B	B	5	T 4
21	37.4	99	—/18		144/70	94	3				96									
22	37.6	108	—/18		131/68	85	3				94									
23	37.9	115	—/18		126/66	82	3				95									
24	37.7	115	5/18		122/64	83	4				95			0 3	4	4	B	B	5	T 4
01	38.4	117	—/18		124/65	79	5				95									
02	38.4	115	—/18		118/64	79	4				95		Labs, ABG							
03	37.7	117	—/18		139/73	85	6				94		CXR							
04	38.7	120	—/18		120/66	85	5				95			0 3	4	4	B	B	5	T 2
05	38.9	118	—/18		134/70	88	5				96									
06	38.8	120	1/18		122/67	83	6				95									
07	38.4	114	2/18		117/71	87	6				98									

UP# 411230 rev 8/03

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 2007

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
Attestation for Am Shift	MW		
Suzanne Hartmann RN 3H 19-7:30	CH		

UP# 411230 rev 8/03

NRSRECRD

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P:490943644 DOB:01/01/1951 L M
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HECTOR
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 2007

IV SOLUTIONS / ADDITIVES

TIME	NS-20 Meq KCl/L IV	Insulin 1 unit/ml	Diazepam 0.5 mg/ml	Ativan 1 mg/ml	IV Meds							A-line Flush	BLOOD PRODUCTS COLLOIDS				NUTRITION TYPE	PO	TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	10 / 10	3.4 / 3	2 / 2	1 / 1								3 / 3					Promod		60 / 60	79	79
09	10 / 20	5 / 8	2 / 4	1 / 2								3 / 6							60 / 120	81	160
10	10 / 30	5.8 / 14	2 / 6	1 / 3								3 / 9							70 / 190	92	252
11	10 / 40	7.7 / 22	2 / 8	1 / 4								3 / 12							70 / 260	94	346
12	10 / 50	6.9 / 29	1 / 9	1 / 5								3 / 15						30 / 30	70 / 330	112	458
13	10 / 60	7.7 / 36	1 / 10	1 / 6								3 / 18							70 / 400	93	551
14	10 / 70	6.9 / 44	1 / 11	1 / 7								3 / 21							70 / 470	92	643
15	10 / 80	5.5 / 50	1 / 12	1 / 8	50 / 50							3 / 24							70 / 540	91	734
16	10 / 90	4.2 / 54	1 / 13	1 / 9								3 / 27							70 / 610	89	823
17	10 / 100	5 / 59	1 / 14	1 / 10								3 / 30							70 / 680	90	913
18	10 / 110	7.9 / 67	1 / 15	1 / 11								3 / 33						30 / 30	70 / 750	93	1006
19	10 / 120	7.6 / 75	1 / 16	1 / 12								3 / 36							70 / 820	93	1099
20	10 / 130	9.9 / 85	1 / 17	1 / 13								3 / 39							70 / 890	95	1194
21	10 / 140	6 / 91	1 / 18	1 / 14								3 / 42							70 / 960	92	1286
22	10 / 150	8.2 / 99	1 / 19	1 / 15								3 / 45							70 / 1030	94	1380
23	10 / 160	8.1 / 107	1 / 20	1 / 16								3 / 48							70 / 1100	99	1479
24	10 / 170	10.5 / 117	1 / 21	1 / 17								3 / 51						30 / 60	70 / 1170	98	1577
01	10 / 180	11 / 128	1 / 22	1 / 18								3 / 54							70 / 1240	96	1673
02	10 / 190	7 / 135	1 / 23	1 / 19								3 / 57							70 / 1310	92	1765
03	10 / 200	7.6 / 142	1 / 24	1 / 20								3 / 60							70 / 1380	91	1856
04	10 / 210	10.3 / 152	1 / 25	1 / 21								3 / 63							70 / 1450	93	1949
05	10 / 220	10.4 / 162	1 / 26	1 / 22								3 / 66							70 / 1520	93	2042
06	10 / 230	8.8 / 170	1 / 27	1 / 23								3 / 69						30 / 90	70 / 1590	124	2166
07	10 / 240	12.2 / 180	1 / 28	1 / 24								3 / 72							70 / 1660		

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 2007

page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

(0715) Report Recieved from Night Nurse, Chart reviewed MW (0800) Physical Assessment performed and documented per Flowsheet. PT Resting In Bed No S/sof Distress MW (1000) Temp 39.4 CC Team Notified Treated Per MAR, MW (1120) Temp 39.1 Room Cooled PT Resting In Bed No S/sof Distress MW (1400) PT Resting In bed. See flowsheet for Vitals (1700) Family Present & Interpreter family spoke to CC Team. MW Late Entry (1200) 16FR OG Tube Inserted without Difficulty, PT Tolerated Well. NG Tube D/C'd. TF Restarted MW (1900) Recieved report from offgoing RN Assumed care of patient. Chart check, drip check completed. Nursing assessment completed. Warmpack to forearm R foot. SH (2200) Art line tubing, dressing changed. SH (0200) Assessment performed. SH (0600) Ortho assessment (700) Report to oncoming RN. SH

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NRSRECRD

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STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS								BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	Foley	STOOL	EMESIS	OG/NG	RESID										
08	200	200	200/200				20 R										
09	375	175	175/375				30 R										
10	1325	950	950/1325														
11	1575	250	250/1575														
12	1700	125	125/1700				10 R										
13	1825	125	125/1825														
14	1025	100	200/1025														
15	1150	125	125/1150														
16	1425	275	275/1425				10 R										
17	1525	100	100/1525														
18	1725	200	200/1725														
19																	
20	1900	175	175/1900				0 R										
21	2000	100	100/2000														
22	2800	800	800/2800														
23	2950	150	150/2950														
24	3150	200	200/3150				0 R										
01	3350	200	200/3350														
02																	
03	3450	100	100/3450														
04	3575	125	125/3575				0 R										
05	3625	50	50/3625														
06	3700	75	75/3700														
07	3875	175	175/3875														

250 200 325 225

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VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/5/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(R) Pedal	D/I	0800	(P) BR (A) WF
P	S	L Pedal	D+I	2100	HBR FWF

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: PIV #18 Insert Date: 11/5/07

	Site	Appearance	Dressing	Blood Return
A	(R) FA	S	D/I	(+)
P	LFA	S	D+I	(+)

Line #2 Type: PIV #18 Insert Date: 11/5/07

	Site	Appearance	Dressing	Blood Return
A	(R) Arm	S	D/I	(+)
P	R Arm	S	D+I	(+)

Line #3 Type: QLC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	(L) SC	S	D/I	(+)
P	LSC	S	D+I	(+)

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

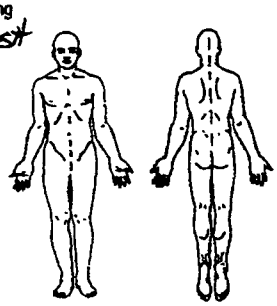
Abnormal Findings

☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☒A ☐P Receiving analgesic therapy Oxycodone 5mg

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P *Cramping*
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling



Location of pain (on the diagram, put an X on the area where the patient complains of pain)

○ Any problems identified, implement **Comfort** section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☒ Psychosocial / Spiritual / Education	M	M
☒ Comfort	M	M
☒ Neurologic / EENT	M	M
☒ Safety	M	M
☒ Functional / Musculoskeletal	M	M
☒ Skin / Wound	M	M
☒ Cardiovascular	M	M
☒ Respiratory	M	M
☒ Gastrointestinal	M	M
☒ Genitourinary	M	M
☒ Nutrition	M	M
☐ Discharge Planning		
☐ Other		

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE _____ TIME 0800

PM SHIFT ASSESSMENT
SIGNATURE _____ TIME 2000

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* N R S R E C R D *

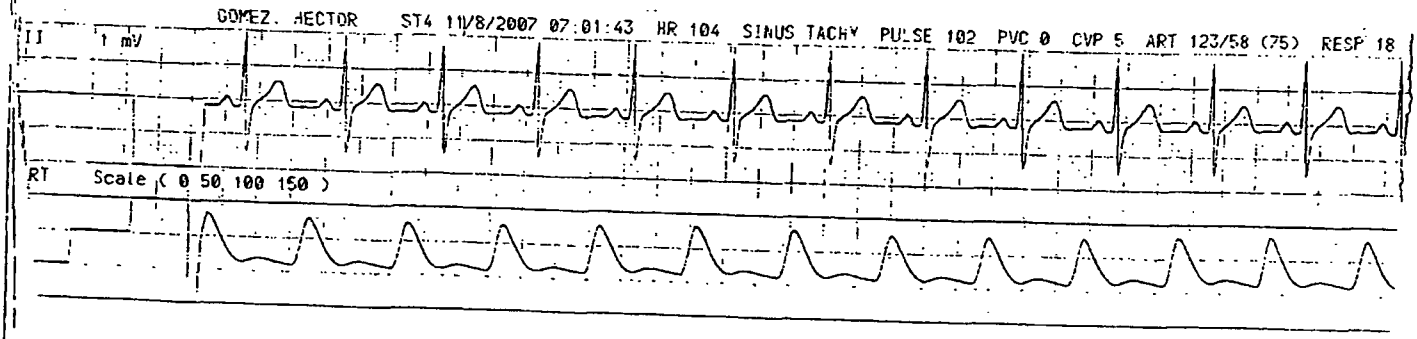
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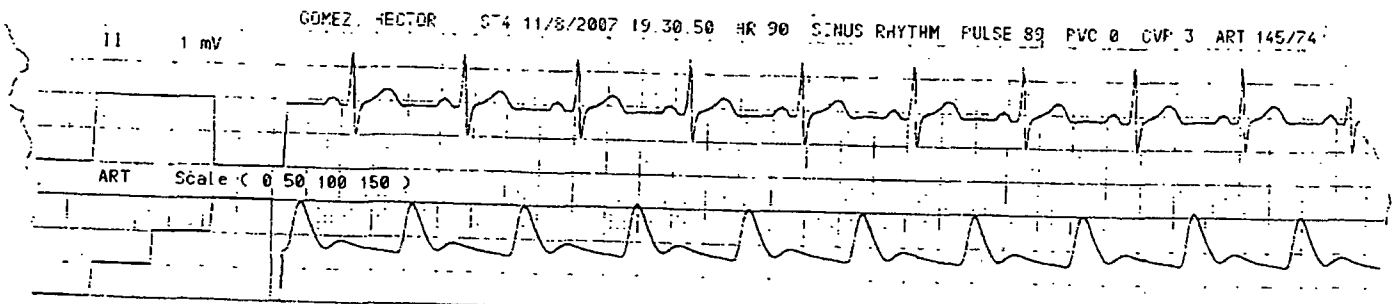
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page 5 of 12

THIS SPACE MONITOR STRIPS





PR 0.18 QRS 0.06 QT 0.32 RRR S. Hartmann RN

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SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	SX Th,T	SX Th,T	SX Th,T	SX Th,T	SX	SX	SX Th,T	SX			SX Th,T	
HOB>30 degrees unless contraindicated	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A line site ✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IV site ✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chest tube patent ✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
NG/OG place ✓ d/c to OG	OG Air Bolus							NA				
Mouth care	✓	✓	✓	✓	✓	✓	✓	✓	✓		✓	
Turn / Passive ROM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Side Rails	4X2							÷	X3			
Incen. Spir./ deep breathe	Vent								Vent	✓	✓	✓
Alarms on / Assessment reviewed	MN	MN	MN	MN	MN	MN	MN	SH	✓ SH	✓ SH	✓ SH	✓ SH

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 2007

page 7 of 12

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.
☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.
☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA
☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.
☐ A ☑ P Chemical paralysis/sedation ~~Precedex~~ diprivan Ativan

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	2	2	2	2
P	2	2	2	2

Reflexes Absent
☐ A ☐ P Cough ☐ A ☐ P Gag
☐ A ☐ P Corneal

Drainage
☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea
☐ A ☐ P Eye
1- clear 2-cloudy 3-bloody

Drain Type:

Location:						
	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices
☑ A ☑ P Cervical collar Miami J
☐ A ☐ P Cervical traction
☐ A ☐ P Halo
☐ A ☐ P Tongs
☐ A ☐ P Shunt: _____
☐ A ☐ P Codman reference # _____
☐ A ☐ P Other _____

Impairments
☐ A ☐ P Hearing
☐ A ☐ P Eyes
☐ A ☐ P Unable to assess

Fontanel
☐ A ☐ P Full ☐ A ☐ P Bulging
☐ A ☐ P Sunken

Emotional status
☐ A ☐ P Inconsolable

✓ Any problems identified, implement **Neurologic / EENT** section of the **POC**.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart
☑ A ☐ P Arrhythmia SR-ST
☐ A ☐ P Click
☐ A ☐ P S3
☐ A ☐ P Distant heart sounds
☐ A ☐ P S4
☐ A ☐ P Rub
☐ A ☐ P Capillary refill > 3 sec.

Murmur
☐ A ☐ P Faint
☐ A ☐ P Moderate
☐ A ☐ P Loud
☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	+1	+1	+1	+1	
P	+1	+1	+1	+1	

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P					

Pacemaker / wires
☐ A ☐ P Permanent ☐ A ☐ P Transvenous
☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial
Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter
☐ A ☐ P AICD

✓ Any problems identified, implement **Cardiovascular** section of the **POC**.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.
☑ A ☑ P: Suction functioning
☑ A ☑ P: Ambu bag/mask present

Abnormal Findings

Respirations
☐ A ☐ P Labored ☐ A ☐ P Shallow
☐ A ☐ P Irregular ☐ A ☐ P Orthopnea
☐ A ☐ P Stridor ☐ A ☐ P Pleural rub
☐ A ☐ P Accessory muscle use
☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation
☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	D	R	D
P	R	R	D	R	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	7.0	—	24
P	ET	7	—	24

☐ A ☐ P Emergency trach supply box
☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage
S=serous; SS=serosanguinous; B=bloody; P=purulent
Air leak / SQ emphysema
P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

✓ Any problems identified, implement **Respiratory** section of the **POC**.

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"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 6 mg NOT: 6.0 mg
Write a decimal point with a leading zero:
USE: 0.8mg Not: .8 mg

Date	Time	
11/8/07		ortho
	6am	stable overnight
		T 98.5 97 120/60 18 92% vent
		sedated, intubated
		RLE: toes 2-5 darker purple but demarcation unchanged
		DP & PT remain strong
		cannot assess neurologic exam
		s/p POD #4 s/p pinning ② 2-5th toe fx from crush injury
		- cont RLE elevation
		- lidocaine injected yesterday to ↓ vasospasm
		- watch for signs of infection
		- await extubation to perform detailed neuro exam of RLE
		Amy Slate 13668

prgrecrd1

OTE 700222 Rev. 9/06

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/6/07	1640	S/O/G/A ⊖ acute events - Gas was poor, FiO_2 ↑ to 60%. ⊖ other issues 38.4 38.6 97 18 121/60 95% 2430 | 5850 Gen: NAD, intubated sedated ⊖f/c HEENT: NG/ET in place; ⊕ copious drainage from L nostril Neck: Mi/amic) in place CV: RRR ⊖ M/G/R L 4: 5 Lungs: Coarse BS throughout Abd: soft NT/ND ⊕BS Extrem: RLE toes 2-5 dusky - heating pads in place, ⊕ DP and PT Elevated on wedge. Labs 7.44/46/73/29.7 @ PRVC 550/18/10/60% 146/109/21/98 8.6 3.5/30/1 7.3 4.8 A/P: 77 M/O MVA s/p BFT Head & open skull fx. 1. Pulm: Vent continues to be poor and poor oxygenation following slight improvement after bronchoscopy. Cult show >10,000 GNR. Sensorium to follow. Will d/c to-day 2. CV: ⊖ issues 3. ↑ Neural drainage. Will plan of ICP face/stress if ⊖ improvement 4. ID - febrile on vanc + Zosyn. (cult ⊕ c GNR. 5. Optho: Toes unchanged. on the following. Will allow toes to declare themselves.

prgrecrd1

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INTERDISCIPLINARY PROGRESS NOTES

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
/01/07 M:2581962

ATTENDING PHYSICIAN NOTE

MRN: 2581962

NAME: Gomez, Hector

Date: 11-8-07 Service: TCU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to PRVC 60% 10 550

Upon personally questioning the patient, I can confirm that the following are the key history factors:

Physical Examination: Pulse: 108 BP: 119/62 Resp Rate: 18 T: 99 Input: _____ Output: _____

CVP 5 7.44/46 173/29.7

Neuro: sedated

Eyes:

ENT: ®nostril secretions

CV: RRR, (NL)

Resp: coarse ®

GI/Nutr:

CU/Renal: soft, NDS/NT/+BS

MuscSkel:

Skin: 2+® DP pulses

Psych:

Other: ® toes discolored

1.0 < 1.8

10.9 37 < 343

enterobacter

☑ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.

☐ I have reviewed the results radiographs as documented in the resident's note.

☑ I have personally reviewed pertinent X-ray examinations.

☐ I have personally reviewed the results of additional medical testing and monitor output.

☐ I have personally discussed the case with _____

Diagnoses/Problems

1. Resp Insuff ☐New ☐Improved ☑ Unchanged ☐Worsening
2. Enterobacter pneumonia ☐New ☐Improved ☑ Unchanged ☐Worsening
3. ☐New ☐Improved ☐ Unchanged ☐Worsening
4. Open skull fx ☐New ☐Improved ☑ Unchanged ☐Worsening
5. Classical thoracic spinous process fx ☐New ☐Improved ☑ Unchanged ☐Worsening
6. ☐New ☐Improved ☐ Unchanged ☐Worsening

Management Options/Recommendations

1. ↓ NG to Qd to free sensis
2. ↑ PEEP to 12, ↑ FiO2 to 50%
3. ↓ b lower to 30 mg IV Q 6 PD, add Diamox for T trends
4. D/C Kefzol D/C Zosyn
5.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☑High

☑ Pt is critically ill/injured. I spent 30 minutes providing critical care to this patient.

Overall Condition: ☑Critical ☐Serious ☐Fair ☐Good

Jerry Gold Signature Date _____

UMA #19100-13 revised 11/06

* N R S R E C R D *

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

NOV 0 9 2007

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	Foley	STOOL	EMESIS	FOLEY	RESID			
08	125	125	125				40 R			
09	300	175	175							
10	425	125	125							
11	575	150	150							
12							10 R			
13	650	150	150							
14		480								
15	1475	125	125							
16	1575	100	100							
17	2125		550							
18	2325	200	200							
19	2400	75	75							
20	2475	75	75				0			
21	2535	60	60							
22	2595	60	60							
23	2845	250	250							
24	2980	85	85				0			
01	3125	145	145							
02	3225	100	100							
03	3300	75	75							
04	3375	75	75				0			
05	3515	140	140							
06	3595	80	80							
07	3645	50	50							

UP# 411230 rev 8/03

MUSC
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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5082457

MRN: 002581962
Date Exam Completed: 11/09/2007 04:32
Last Update: 11/09/2007

EXAMINATION: PORTABLE CHEST 11/09/07 04:32:00

ACCESSION NUMBER: 5082457

INDICATION: OPEN SKULL FRACTURE, RESPIRATORY FAILURE

COMPARISON: CXR 11/8/07

FINDINGS: Single frontal radiograph of the chest demonstrates unchanged position of support tubes and lines. Stable size and contour of the cardiomediastinal silhouette. Hila and lungs demonstrate right upper lobe linear atelectasis and left lower lobe segmental atelectasis. Visualized portions of the bony thorax are unremarkable.

IMPRESSION:

1. Unchanged atelectasis of the right upper lobe and left lower lobe.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW
I have reviewed the images and agree with the findings in this report.

History: 27 yo hm sp bft to head with open skull fx

Technologist: LORI RAGER
Interpreter 1: JAMES RAVENEL

Proxy Signer:

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5082457

MRN: 002581962
Date Exam Completed: 11/09/2007 04:32
Last Update: 11/09/2007

Interpreter 2: MARQUES BRADSHAW
Interpreter 3:
Date Dictated:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/9/2007

Transcribed by: Tech IntTalk

NRSRECRD

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 9 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

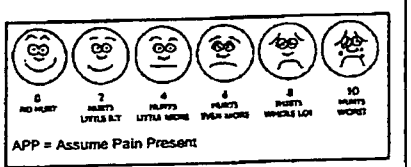
VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # _____



1 2 3 4 5 6 7 8 9MM

TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S_aO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN / SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR R	MOTOR L	VERBAL / EYES
08	38.4	123	17		133/70	88	7				94			0 3	3 B	3 B			5 5		E T 2
09	38.4	121	18		139/75	90	5				94										
10	38.8	122	18		134/73	96	5				95		CC Rounds								
11	38.5	111	18		143/75	91 93	3				97										
12	38.4	109	18		144/75	93	2				97			6 3	4 B	4 B			5 5		E T 2
13	38.3	102	18		143/75	93	2				97										
14	38.2	111	18		151/75	91	2				94										
15	38.1	110	18		143/76	93	2				96										
16		108	18		142/76	93	2				96		1059 Bath	0 3	4 B	4 B			5 5		E T 2
17	37.8	121	18		161/93	112	2				94										
18		105	18		133/74	89	1				96										
19	37.5	101	18		139/76	90	1				95										
20	36.8	107	2 28		153/80	96	1				96			UTA	3 B	3 B			4 4		T 3
21	37.6	108	18	84/72	115/72	95	3				95				3 B	3 B			5 5		T 3
22	37.8	108	18		149/75	99	4				95										
23	38.0	108	18		145/75	97	3				95										
24	37.9	116	38		100/76	88	3				93			UTA	3 B	3 B			5 5		T 3
01	37.9	109	18		100/73	87	3				95										
02	37.8	113	18	123/75	107/79	95	5				90										
03	37.0	105	18	128/77		96	5				96										
04	37.2	102	18	125/86		96	6				95			UTA	4 B	4 B			5 5		T 3
05	37.8	124	4 18	135/86		97	4				97										
06	37.6	100	18	124/70		89	4				96										
07	37.5	107	4 18	124/84		93	7				96										

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 9 2007

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM _____

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location A	✓ / location P	Suction A	Suction P	Drainage A	Drainage P
NGT						
OGT	✓		TF	C	TF	
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

✓ Any problems identified, implement **Gastrointestinal** section of the POC.

GENITOURINARY

☐ A ☐ P **WNL:** *Continent with adequate output of clear* yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other sediment

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P *Problematic penile or vaginal bleeding or discharge*
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
✓ Any problems identified, implement **Genitourinary** section of the POC.

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm A	R Arm P	L Arm A	L Arm P	R Leg A	R Leg P	L Leg A	L Leg P
Limited ROM					R	✓		
Weakness		X		X		✓		X
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices	Site / Type
✓ A ☐ P SCD/foot pump	(L) C E
☐ A ☐ P TED	
☐ A ☐ P Traction	
✓ A ☐ P Cast/splint	(R) LE Cast d Elevator
✓ A ☐ P External fixator	Pins (R) 3 toes
☐ A ☐ P Other	

Speech
☐ A ☐ P Slurred ✓ A ☐ P Unable to verbalize ETT
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
✓ Any problems identified, implement **Functional / Musculoskeletal** section of the POC.

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale; ☐ A ✓ P Cyanotic toes > HD; ☐ A ☐ P Jaundice yel
Turgor ☐ A ☐ P Loose; ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool; ☐ A ☐ P Diaphoretic

Skin Impairments

Location

☐ A ☐ P Surgical incision _____
dressing type/appearance _____
✓ A ✓ P Drain Penrose (C) Top Head
☐ A ☐ P Drain _____
☐ A ☐ P Wound _____
dressing type/appearance _____
✓ A ✓ P Other Sutures (C) Top Head
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

✓ Any problems identified implement **Skin/Wound** section of the POC.

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	Sx Th-T	Sx Th,T	Sx —	Sx Th,T	Sx —	Sx Th,T	Sx Th,W	Sx Th,W	Sx Th,W	Sx Th,W	Sx Th,W	Sx Th,W
HOB>30 degrees unless contraindicated	✓	✓	✓	✓	✓	✓	30°	30°	30°	30°	30°	30°
A line site ✓	✓	✓	✓	✓	✓	✓	DJ	25	25	25	25	25
IV site ✓	✓	✓	✓	✓	✓	✓	DJ	25	25	DJ	25	25
Chest tube patent ✓	—	—	—	—	—	—	Ø	Ø	Ø	Ø	Ø	Ø
NG/OG place ✓	(T) Ac Bolus	—	—	—	—	—	DJ	25	25	25	25	25
Mouth care	✓	—	✓	✓	—	✓	DJ	25	25	25	25	25
Turn / Passive ROM	✓	✓	✓	✓	✓	✓	DJ	25	25	25	25	25
Side Rails	PKd	—	—	—	—	T	X2	X2	X2	X2	X2	X2
Incen. Spir./deep breathe	Vent	—	—	—	—	T	Vent	Vent	Vent	Vent	Vent	Vent
Alarms on / Assessment reviewed	MN	MN	MN	MN	MN	MN	DJ	25	25	25	25	25

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 9 2007

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☒ P Glasgow coma scale < 15 in non-sedated state.

☒ A ☐ P Chemical paralysis/sedation Precedex Ativan

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A				
P	1	1	1	1

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☒ A ☒ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☒ A ☐ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

☒ Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☒ A ☐ P Arrhythmia SR - ST

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	+1	+1	+1	+1	
P					+1

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P					

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

☒ Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☒ A ☒ P: Suction functioning

☒ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	D	R	D
P	R	R	R	R	R

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	7.0	—	24
P	ET	7.0	4	22

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☒ Any problems identified, implement **Respiratory** section of the POC.

NRSRECRD

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page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	NS ~30 Meq/L Heparin 1K	Insulin 1 unit/ml	Dilaudid 0.5 mg/ml	Ativan 1 mg/ml	IV Meds							A-line Flush	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	10 / 10	12.2 / 12	1 / 1	1 / 1								3 / 3		Promote		70 / 70	97	97
09	10 / 20	12.2 / 24	1 / 2	1 / 2								3 / 6				70 / 140	97	194
10	10 / 30	11.3 / 35	1 / 3	1 / 3								3 / 9				70 / 210	96	290
11	10 / 40	12.2 / 47	1 / 4	1 / 4								3 / 12				70 / 280	97	387
12	10 / 50	7.8 / 55	1 / 5	1 / 5								3 / 15			30 / 30	70 / 350	124	511
13	10 / 60	9.2 / 65	1 / 6	1 / 6								3 / 18				70 / 420	94	605
14	10 / 70	16.4 / 81	1 / 7	1 / 7	50 / 50							3 / 21				70 / 490	141	746
15	10 / 80	19.7 / 94	1 / 8	1 / 8								3 / 24				70 / 560	94	840
16	10 / 90	10.3 / 104	1 / 9	1 / 9								3 / 27				70 / 630	95	935
17	10 / 100	11.3 / 115	1 / 10	1 / 10								3 / 30				70 / 700	96	1031
18	10 / 110	15.3 / 130	1 / 11	1 / 11								3 / 33			30 / 60	70 / 770	130	1161
19	10 / 120	5 / 135	1 / 12	1 / 12								3 / 36				70 / 840	90	1251
20	10 / 130	17 / 152	0.5 / 12.5	0.5 / 12.5								3 / 39				70 / 910	150	1351
21	10 / 140	13 / 165	1.5 / 14	1.5 / 14								3 / 42				70 / 980	95	1446
22	30 / 170	23 / 188	0.5 / 14.5	0.5 / 14.5	50 / 100							3 / 45				70 / 1050	140	1586
23	10 / 180	11 / 199	1.5 / 16	1.5 / 16								3 / 48				70 / 1120	95	1681
24	10 / 190	6.3 / 205	0.5 / 16.5	0.5 / 16.5								3 / 51			30 / 90	70 / 1190	120	1801
01	10 / 200	6 / 211	0.5 / 17	0.5 / 17								3 / 54				70 / 1260	97	1898
02	10 / 210	14 / 225	0.5 / 17.5	0.5 / 17.5								3 / 57				70 / 1330	102	2000
03	10 / 220	13 / 238	1 / 18.5	1 / 18.5								3 / 60				70 / 1400	98	2098
04	10 / 230	6 / 244	1 / 19.5	1 / 19.5								3 / 63				70 / 1470	91	2189
05	10 / 240	6.1 / 250	1 / 20.5	1 / 20.5								3 / 66				70 / 1540	95	2284
06	10 / 250	16.5 / 266	1 / 21.5	1 / 21.5	50 / 150							3 / 69			30 / 120	70 / 1610	131	2415
07	10 / 260	6.5 / 272	1 / 22.5	1 / 22.5								3 / 72				70 / 1680	92	2507

UP# 411230 Rev 8/03

MUSC
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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 9 2007
page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0715 Report Recieved from Night Nurse, Chart Reviewed MN 0800 Physical Assessment performed and documented per Flowsheet MN 1200 See Flowsheet for Vitals, Vent D/S MN 1450 linen D and bath MN 1845 pt Resting In Bed No S/S of Distress MN 1910 Report rcvd, care assumed, chart rcvd - pain/sedation meds off for neuro exam 2000 pain/sedation meds remain off - pt withdraws only to painful stimuli - will open eyes to verbal command 2100 Pt able to localize Bilaterally pain/sedation on Hr dose 0100 dampen O into of Blood into I Aline & correlating, trouble shoot I success 0230 RT aware of problems - A-line DCS I cathetin intact - pt more responsive - pain/sedation meds back to dose of 1mg/hour - titrate .5mg/hr Q4hrs/prn - will continue to monitor & adjust as needed 0300 Labs drawn/pending ABGs obtained 0500 complete bath & skin breakdown noted - some abrasions noted to LUE & buttocks R shoulder - pt also moving RLE off wedge 0700 Report pending to oncoming Shift

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☐ Allergy band on
- ☐ Call system accessible
- ☑ Bed in low position
- ☑ Bed brakes on
- ☑ Bed alarms on
- ☑ Bed heel pressure relief
- ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ History of falls
  - ☐ Withdrawal from addictive substances
  - ☐ Violent behavior
  - ☐ Previous use of restraints
  - ☐ Other _____
- ○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	(<59)	60-70	71-80	81+
Mental Status	Oriented & cooperative	(Comatose) Sedated	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	(New onset - admitted for acute episode/tx)	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	(Catheter or ostomy)	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	(Visual, hearing, language/speech)	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	(Physically unable to walk/stand (but may attempt to))	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	(No history)	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	(Three or More of the medications below)

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:	0	4	0	3
TOTAL POINTS:	7	☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS
INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					
TRACH CARE					
BATH	1650 MW				
FOLEY / PERI CARE	1650 MW				
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE	1650 MW				
SKIN CARE	1650 MW				
PEG SITE CARE					
TYPE OF DIET	TF				
% EATEN	TF				
PACING WIRES INSULATED SECURED					
SPECIALTY BED	TCU				
	MTamies				

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 9 2007

page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES			HEMATOLOGY				CHEMISTRY								
TYPE O, DEL	MODE RATE	FiO2 TV	PEEP PS	CPAP PIP	MIN VENT		A/V PH	PO2 PCO2	HCO3 O2SAT	HCT HGB	WBC RBC	PT PTT	PLT INR	NA K	CL CO2	GLUC BUN	CREAT CA	MG PHOS		FSBS		
Vent	PRVC 18	50 520	12																	118 0.2		08
	40					0930	A 7.35	89 40	28.6 96											111 0.21		09
																				114 0.23		10
																				111		11
																				106 .23		12
																				89 .23		13
																				141 .22		14
							A 7.51	89 38	21.3 96.4											103 .23		15
																				107 .23		16
																				121 .24		17
							A 7.41	83 35	28.0 97.4											81 .25		18
																				138 .24		19
Vent	PRVC 12	40 520	8																	109 .25		20
																				97 .24		21
																				106 .24		22
																				112 .25		23
																				87 .24		24
																				139 .25		01
																				112 .25		02
							A 7.46	142 30	20.6 99.3	35.5 11.9	10.9 3.91	15.1 29.9	3.3 1.15	135 3.7	108 20	32 27	0.9 9.1	2.3 2.2		86 .24		03
																				102 .24		04
																				125 .20		05
																				87 .18		06
																				90 .20		07

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page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/5/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(L) Radial	DIE	0800	(+) BA (+) WE
P	S	(R) Radial	DII	2000	(+) Rt Rem (+) WF

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: PIV #18 Insert Date: 11/5/07

	Site	Appearance	Dressing	Blood Return
A	(L) FA	3	DIE	(-)
P	(-)			

Line #2 Type: PIV #18 Insert Date: 11/5/07

	Site	Appearance	Dressing	Blood Return
A	(R) Arm	3	DIE	(-)
P	(-)			

Line #3 Type: QLC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	(L) SC	3	DI	(+)
P	(L) SC	3	DI	(+)

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

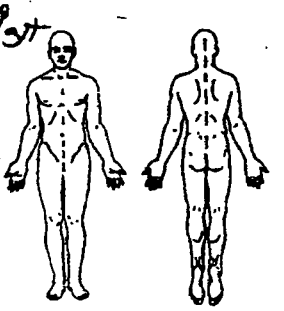
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☑P Receiving analgesic therapy Dilaudid gtt

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: 4/5 Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



○ Any problems identified, implement Comfort section of the **POC.**

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

☒ **Psychosocial / Spiritual / Education** A M P M
☒ **Comfort** A M P M
☒ **Neurologic / EENT** A M P M
☒ **Safety** A M P M
☒ **Functional / Musculoskeletal** A M P M
☒ **Skin / Wound** A M P M
☒ **Cardiovascular** A M P M
☒ **Respiratory** A M P M
☒ **Gastrointestinal** A M P M
☒ **Genitourinary** A M P M
☒ **Nutrition** A M P M
☐ **Discharge Planning** A _____ P _____
☐ **Other** _____ A _____ P _____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE 0800 TIME

PM SHIFT ASSESSMENT
SIGNATURE 2000 TIME

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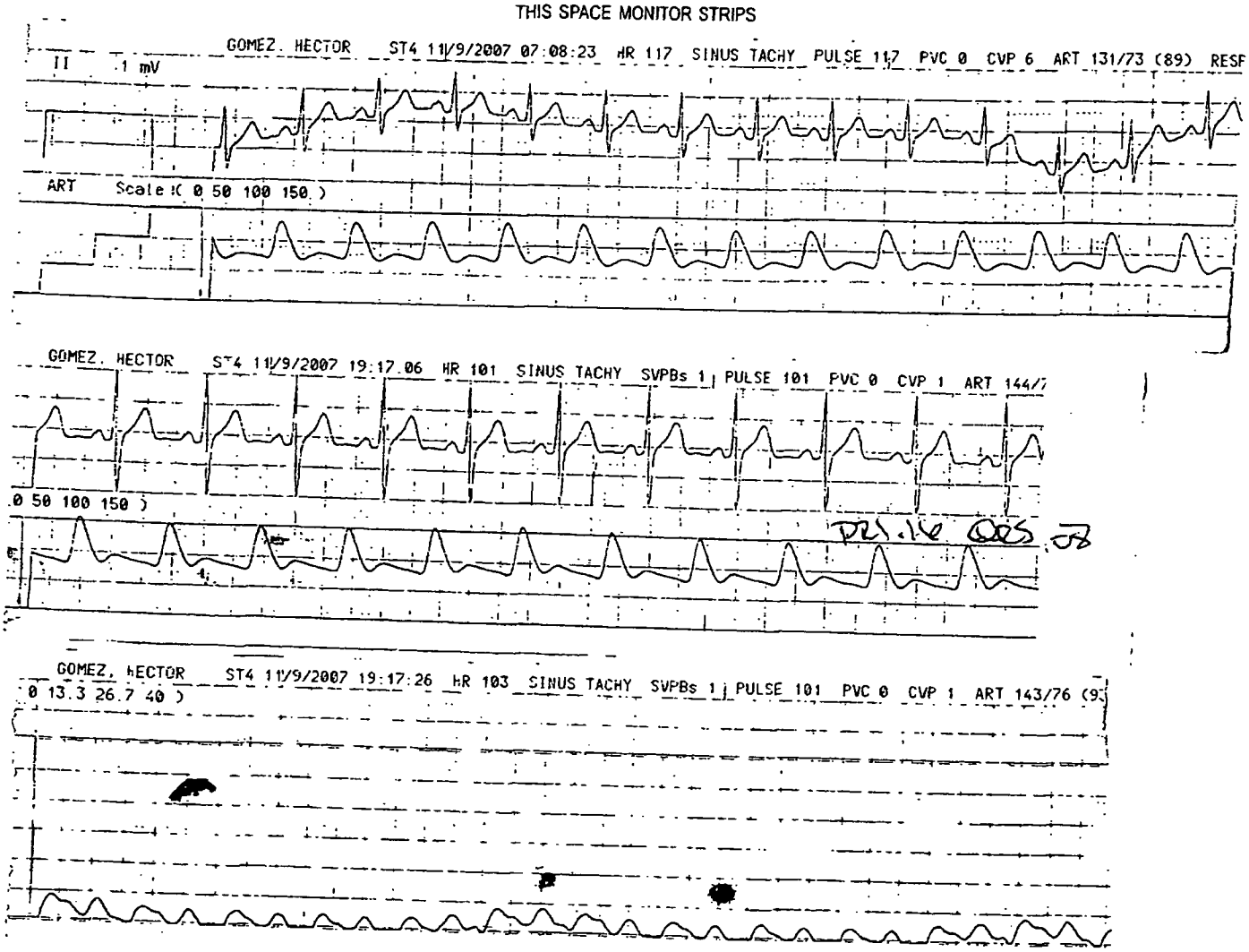
NRSRECRD

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 9 2007

THIS SPACE MONITOR STRIPS



UP# 411230 rev 8/03

"PRGRECRD"

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/9/07	640AM	ORTHO. MSY PN Ø events overnight 38° 114 "7/77 (87) 95% vent sedated, intubated RLE - toes unchanged from previous exam demarcation line not traveling. A/P POD #3 5/8 pinning ® 2-5TH toe fx from crush injury - toes likely devascularized from crush injury. - cont to wait for toes to declare themselves. - watch for S/S of infection - await extubation Agree c above MSY note. DP/PT Doppler WILLIAMS MSY with good flow to foot but crush injury has likely devascularized toes. Will follow closely. Gay Sellers 1566

prgrecrd1

OTE 700222 Rev. 9/06

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
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USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/9		STICU/CC
	0700	No events o/n.
		39° 38° 114 2/18 117/72 · 98% PRVC 450/12/PEEP 12/40% FiO2
NS		I/O 2250/3875 70 ml/h TF@ 70
Insulin, gtt		
Diprivan, gtt		Sedated
Ativan, gtt		PERL
		RRR
		bBS @ LLB
		Abd S, ND
		(R) toes unchanged - dusky color to toes, #2-5
		7.36/84/41/96%/22.5
		A/P: s/p CHI skull fx, (R) multiple rib fx
		① Neuro - Ativan @ 1 mg/hr.
		② CV - ♦ pressors
		③ Resp - ↓O2 requirement. Consider SBT soon
		④ Renal - cont Q8 fluids
		⑤ ID - cont Meropenem
		⑥ Endo - cont Insulin gtt
		⑦ Proph - SCDs, pepcid, enteric
		⑧ MS - heat packs to (R) foot

1535

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

ATTENDING PHYSICIAN NOTE

MRN: 2581962

NAME: Gomez, Hector

Date: 11-9-07 Service: PCU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to PRVC 40% 12 18 450

Upon personally questioning the patient, I can confirm that the following are the key history factors: 7.38/40/85/22E

Physical Examination: Pulse: 114 BP: 139/72 Resp Rate: 18 T: 99 Input: 2250 Output: 3875 CVP=5

Neuro: sedated
Eyes: PERRL
ENT:
CV:
Resp: coarse
GI/Nutr: soft, ND, +BS
GU/Renal:
MuscSkel:
Skin: 2+ DP pulses
Psych:
Other: ETT unchanged - distal

63 1.22 100 1

10.3 283 35.1

☒ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☒ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☐ I have personally discussed the case with

Diagnoses/Problems

1.	Resp Failure	☐New	☐Improved	☒ Unchanged	☐Worsening
2.	Enterobacter pneumonia	☐New	☐Improved	☒ Unchanged	☐Worsening
3.		☐New	☐Improved	☐ Unchanged	☐Worsening
4.	Open skull fx	☐New	☐Improved	☒ Unchanged	☐Worsening
5.	C4 spinous/transverse fxs	☐New	☐Improved	☒ Unchanged	☐Worsening
6.		☐New	☐Improved	☐ Unchanged	☐Worsening

Management Options/Recommendations

1.
2. Continue basic diuresis
3. Wean vent as tolerated, hopefully be able to d/c PEEP
4.
5. Continue Abx
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☒High

☒ Pt is critically ill/injured. I spent 30 minutes providing critical care to this patient.

Overall Condition: ☒Critical ☐Serious ☐Fair ☐Good

Signature Date

UMA #19100-13 revised 11/06

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

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Patient Name
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Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/9/07	1500	TDT meeting: Case discussed - Pt S/P crane accident - pneumonia, on vent, febrile, Status as per Brooks. NCM / CHG nurse + Operations coordinator - /t Simmons rn
11/10/07	1800	ortho Ø acute issues overnight 37° 100 124/92 18 95% vent sedated, intubated RLE: DP strong to foot, toes still warm 2-5 toes with worsening color, demarcation unchanged unable to assess sensory / motor fxn a/p s/p crush injury to Rt foot - wound 2-5 toes are becoming necrotic. No intervention, will have to wait for them to declare + decide future tx @ that time. Cont elevation - await extubation to further evaluate motn / sensory fxn. Amy Fletcher 15668
	Am	

prgrecrd1

OTE 700222 Rev. 9/06

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5083957

MRN: 002581962
Date Exam Completed: 11/10/2007 03:05
Last Update: 11/11/2007

EXAMINATION: SINGLE VIEW OF THE CHEST 11/10/07 03:05:00

ACCESSION NUMBER: 5083957

INDICATION: 37 y/o male struck by crane. Required ventilation for 5 days. Increasing A-a gradient

COMPARISON: 11/9/07

FINDINGS: Single frontal radiograph of the chest reveals the cardiac silhouette to be normal in size and configuration. Right upper lobe and left lower lobe atelectasis is again noted, slightly improved from the previous exam. Endotracheal tube, enteric tube and left central venous catheter unchanged. Right clavicular fractures is unchanged as well.

IMPRESSION:

Slightly improved ventilation with stable support lines and tubes.

VOICE DICTATED BY: Dr. Matt Murray
I have reviewed the images and agree with the findings in this report.

History: 37 y/o male struck by crane. Required ventilation for 5 days. Increasing A-a gradient

Technologist: WES LINEBERRY
Interpreter 1: UWE SCHOEPF

Proxy Signer:

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:40 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5083957

MRN: 002581962
Date Exam Completed: 11/10/2007 03:05
Last Update: 11/11/2007

Interpreter 2: MATTHEW MURRAY
Interpreter 3:
Date Dictated:

Authenticating Radiologist: JOSEPH SCHOEPF
Date Authenticated: 11/11/2007

Transcribed by: Tech IntTalk

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962
(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 10 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

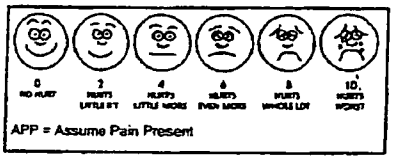
VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # _____





TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL EYES
08	37	100	- / 18	124/72		90					95			0	3	4	B	4	B	5	5	V 1
09		95	- / 18	121/73		89					97											
10		102	- / 18		146/91	109					97											
11		98	- / 18		145/87	101					96											
12	37	99	- / 18		151/85	100					96											
13		105	- / 18		134/75	92					97											
14		99	- / 18		124/73	86					97											
15		97	- / 18		123/71	84					97											
16		100	- / 18		121/73	87					98											
17	37.5	112	- / 18		135/79	100/95					100											
18		120	2 / 18		147/81	88					98											
19		96	- / 18		115/73	88					98											
20	37.5	96	- / 18		124/75	98	8				97				3	4	B	4	6	5	5	ET 3
21		98	- / 18	122/73	118/73	88					97											
22	37.5	103	- / 18		114/71	85	6				96											
23		104	- / 18		126/80	94					98											
24	37.7	107	- / 18		124/71	91	11				96				3	4	B	4	B	5	5	ET 2
01		104	- / 18		116/72	86					96											
02	37.8	105	- / 18		121/76	90	11				96											
03		103	- / 18		121/77	91					97											
04	37.8	109	- / 18		125/79	94	11				98				3	4	B	4	B	5	5	ET 2
05		103	- / R		117/70	84					96											
06	37.7	105	- / 18		119/71	95	21				95											
07		100	- / 18		119/74	89					96											

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HECTOR
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 10 2007

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
[signature]	[initials]		
Farrah Cathers, RN 7p-7a	[initials]		

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	Insulin (Units)	Dilaudid (mg)	Versed (mg)	Ativan (mg)	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	7.1	1	10	1		promod		70	91.1	89.1
09	7.1	1	10	1				70/140	89.1	178.2
10	11.3	1	10	1				70/210	89.8	267.8
11	13.3	1	10	1				70/280	91.8	359.6
12	12.3	1	10	1		flush	30/60	70/350	126.3	485.9
13	11.4	1	10	1				70/420	99.8	585.7
14	9.5	1	10	1				70/490	151.6	737.3
15	11.3	1	10	1				70/560	99.8	837.1
16	11.3	1	10	1				70/630	93	930.1
17	11.3	1	10	1				70/700	93	1023.1
18	15.4	1	10	1		flush	30/60	70/770	117.1	1140.2
19	13.4	1	10	1				70/840	91	1231.2
20	13.3	1	10	1				70/910	91	1322.2
21	15.3	1	50	1				70/980	132	1454.2
22	16.3	1	10	1				70/1050	95	1549.2
23	17.3	1	10	1				70/1120	89	1638.2
24	15.2	1	10	1			30/90	70/1190	124	1762.2
01	19.4	1	10	1				70/1260	92	1854.2
02	20.4	1	10	1				70/1330	90	1944.2
03	21.4	1	10	1				70/1400	91	2035.2
04	22.4	1	10	1				70/1470	93	2128.2
05	19.4	1	10	1				70/1540	92	2220.2
06	24.2	1	10	1			30/120	70/1610	122	2342.2
07	24.2	1	50	1				70/1680	92	2434.2

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NOV 10 2007

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0730 Assumed Care of pt Report received. Assessment Completed & note. Med given 0930 @ Changes noted 1150 @ Change noted 1330 @ Changes noted. 1530 @ Changes noted. Pt bathed / linens changed 1730 @ Chart note 1900 Report given to oncoming RN

1900-Report Received. Chart Reviewed Care Assumed. FG 2000- Assessment Completed, refer to record for complete assessment. Pt opens eyes to speech/PERRL. Localization BUE to noxious stimuli. BLE appropiate movement noted. Dilaudid/Ativan gtt infusing. Insulin gtt infusing c hourly titration per protocol. OGT c TF. (R) Toes x4 black c pins inserted/warm. Alarms On. Will monitor. FG 2200- No changes @ present. FG 2400- No changes @ present. Dr Brown @ BS orders received. FG 0200- No changes @ present. FG 0300- Labs Sent. FG 0500- No changes @ present. FG 0715- Report given to on coming nurse. ——— J Walters, RN

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STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

TIME	OUTPUT CUM	OUTPUT HOURLY	URINE	GASTRIC STOOL	GASTRIC EMESIS	GASTRIC OG/NG	GASTRIC RESID	CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
08	100	100	100				0			
09	175	75	75							
10	275	100	100							
11	325	50	50							
12	375	50	50				15			
13	475	100	100							
14	550	75	75							
15	600	50	50							
16	700	100	100				0			
17	810	110	110							
18	850	50	50							
19	1150	300	300							
20	1675	525	525				8			
21	2300	625	100							
22	2400	100	100							
23	2436	36	36							
24	2516	80	80				8			
01	2591	75	75							
02	2651	60	60							
03	2751	100	100							
04	2830	70	70				0			
05	2860	30	30							
06	2900	40	40							Lasix 20 mg
07	2991	75	125							

readjusted

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 10 2007

page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☐ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position
- ☐ Bed brakes on
- ☐ Bed alarms on
- ☑ Bed heel pressure relief
- ☐ On ☐ Off reason: ____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other ____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ Violent behavior
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other ____
- ○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) ____

SUBTOTAL:				
TOTAL POINTS:		☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done
RA = right arm
LA = left arm
RL = right leg
LL = left leg
IJ = internal jugular
EJ = external jugular
SC = subclavian
RF = right femoral
LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					
TRACH CARE					
BATH	1700 Sa				
FOLEY / PERI CARE	1700 Sa				
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE	1700 Sa				
SKIN CARE	1700 Sa				
PEG SITE CARE					
TYPE OF DIET					
% EATEN					
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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* N R S R E C R D *

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 10 2007

page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES				HEMATOLOGY					CHEMISTRY							
	TYPE O_2 DEL	MODE RATE	FiO_2 TV	PEEP PS	CPAP PIP	MIN VENT	A/V PH	PO_2 PCO_2	HCO_3 O_2SAT	HCT HGB	WBC RBC	PT PTT	PLT INR	NA K	CL CO_2	GLUC BUN	CREAT CA	MG PHOS	FSBS	
	Vent	14	40	8															91	08
			510																	09
																			131	10
																				11
																			113	12
																			111	13
																			102	14
																			111	15
																			106	16
																				17
																			82	18
																			97	19
V	PRVC	40	8																104	20
	18	500																	115	21
																			92	22
																			111	23
																			101	24
																			95	01
							A 7.43	77 36	236 95.7	34.2 11.3	10.97 3.88	144 28.9	317 1.12	141 3.6	111 24	100 28	0.9 9.1	2.9 3.7	100	02
																			107	03
																			103	04
																			103	05
																			107	06
																				07

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/6/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(R) Radial	DI	0900	+
P	S	(R) Radial	DI	2000	(+) WF / BB

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: QIC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	(L) SC	S	DI	+
P	(L) SC	S	DI	(+)

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

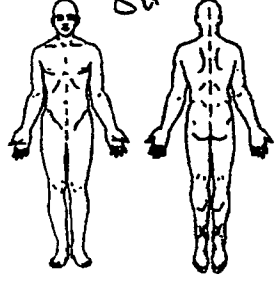
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



○ Any problems identified, implement **Comfort** section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

☐ Psychological / Spiritual / Education A_____ P M
☐ Comfort A_____ P M
☐ Neurological / EENT A_____ P M
☐ Safety A_____ P M
☐ Functional / Musculoskeletal A_____ P M
☐ Skin / Wound A_____ P M
☐ Cardiovascular A_____ P M
☐ Respiratory A_____ P M
☐ Gastrointestinal A_____ P M
☐ Genitourinary A_____ P M
☐ Nutrition A_____ P M
☐ Discharge Planning A_____ P_____
☐ Other _____ A_____ P_____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE _____ TIME 0800

PM SHIFT ASSESSMENT
SIGNATURE Tamara Mathews, RN TIME 2000

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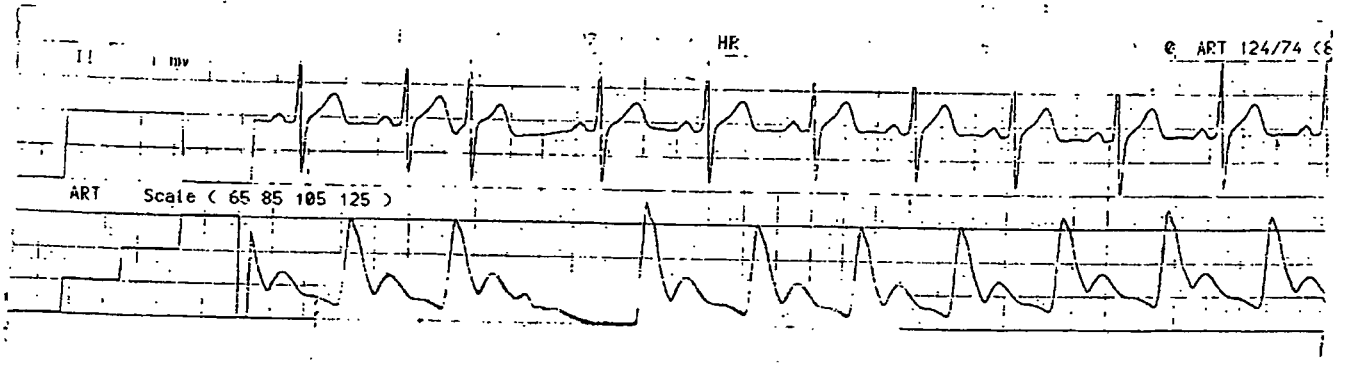
NOV 1 0 2007

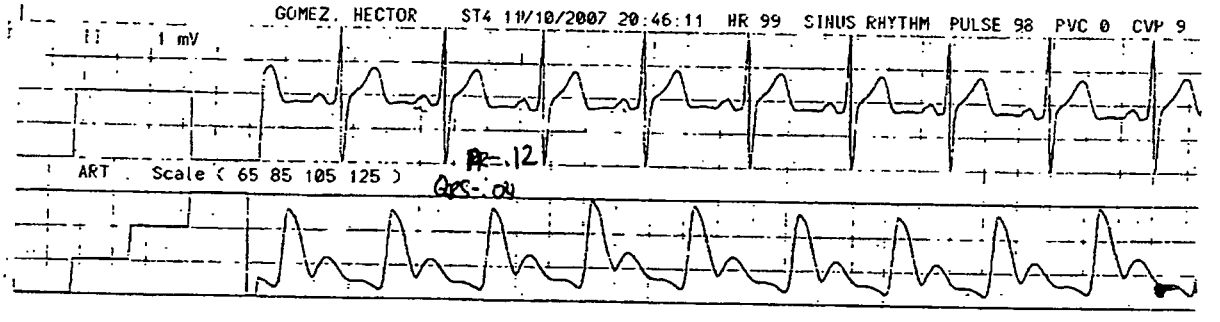
24 HOUR CRITICAL CARE PATIENT RECORD Date _____

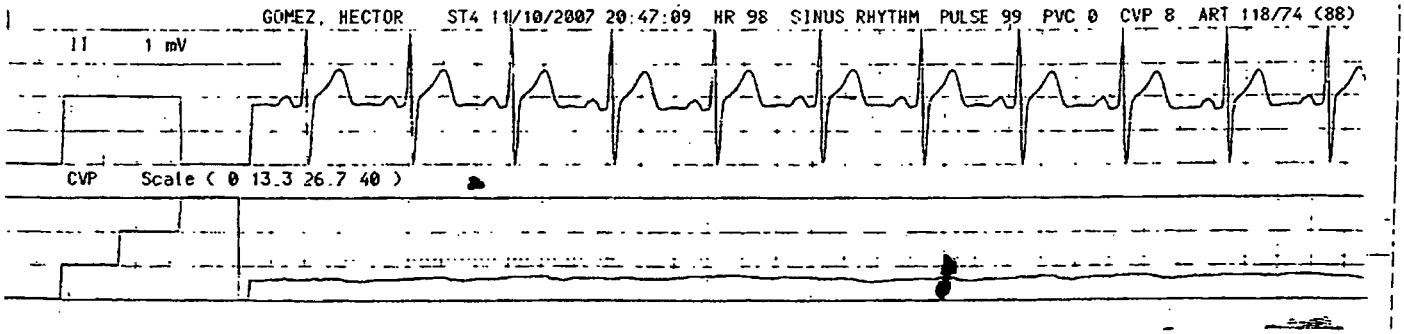
page 5 of 12

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THIS SPACE MONITOR STRIPS







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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 10 2007

page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM _____

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☒ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT		✓ DAR, bilious		F		F
Small bore feeding tube						
G-tube	✓		H—		H—	
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

☐ Any problems identified, implement **Gastrointestinal** section of the POC.

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P Condom ☐ A ☒ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
○ Any problems identified, implement **Genitourinary** section of the POC.

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness		✓		✓		✓		✓
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Site / Type
☐ A ☐ P SCD/foot pump
☐ A ☐ P TED
☐ A ☐ P Traction
☐ A ☒ P Cast/splint (R) LE
☐ A ☐ P External fixator
☐ A ☐ P Other PUNCTURE

Speech
☐ A ☐ P Slurred ☐ A ☒ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the POC.

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race. (R) Toes: Blackened

Abnormal Findings

Color ☐ A ☐ P Pale
☐ A ☐ P Cyanotic toes
☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose
☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool
☐ A ☐ P Diaphoretic

Skin Impairments

Location
☐ A ☐ P Surgical incision _____
dressing type/appearance _____
☐ A ☐ P Drain _____
☐ A ☐ P Drain _____
☐ A ☒ P Wound sacrum - typ of wound
dressing type/appearance _____
☐ A ☐ P Other _____
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

○ Any problems identified implement **Skin/Wound** section of the POC.

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962
(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 10 2007

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	i 4h+u						S	S	S T	S T	S T	S T
HOB>30 degrees unless contraindicated	SM						FG					
A line site ✓	SM						FG					
IV site ✓	SM						FG					
Chest tube patent ✓	N/A						N/A					
NG/OG place ✓	+ air						✓	✓	✓	✓	✓	✓
Mouth care	SM						FG					
Turn / Passive ROM	SM						FG FG	FG FG	FG FG	FG FG	FG FG	FG FG
Side Rails	SM						x2					
Incen. Spir./ deep breathe	SM						Vent					
Alarms on / Assessment reviewed	SM						✓ FG	✓ FG	✓ FG	✓ FG	✓ FG	✓ FG

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☐ A ☐ P Chemical paralysis/sedation Ativan gtt

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	+1	+1	+1	+1
P	1	1	1	1

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:						
	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☐ A ☒ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☐ A ☒ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

☐ Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐ A ☐ P Arrhythmia Sr-Sinus

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A					
P					(+)

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P					

Pacemaker / wires

☐ A ☐ P Permenent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PAcatheter

☐ A ☐ P AICD

☐ Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☒ A ☒ P: Suction functioning

☒ A ☒ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	RC	C	RC		RC
P	R			R	

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	7.0		22
P	ETT	7.0	—	22 cm

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☐ Any problems identified, implement **Respiratory** section of the POC.

PRGRECRD

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P:490943644 DOB:01/01/1951 L M
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HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/10/07	3PM	SICU LPN S: O: Wt/s 70.3 100 124/47 ↑ 96% PRVC 40/1 500/14/6 FiO=24% PEEP/CPAP Neuro: Intubated/Sedated, Follows Commands Pupils 5:4D CV: Tachy S1 S2 Lungs: Coarse BS (B) Abdomen: BS(+) NT/ND Extremities: 2+ DP Labs: 134/104/22/1.42 2.5 2.8 11/11.7/311.3 9.46/30/148/99.6/20.9 317/20/0.9 56.6 A/P: 36 y/o AM Multiple TI Fx's, (B) lower take cautionus (1) Resp: Wean Vent as tolerated (2) CV: Stable (3) ID: Continue ~~FU - Abx~~ Monitor temps (4) Endo: Insulin SSI (5) MSK - DF foot Fx(s) c Necrotizing fasc cont's to form Ortho. Intubated (R) foot in splint. 2-5 toes black, dry, gangarous changes. will follow up daily will make treatment plan with team/attendings 1534 1503

prgrecrd1

OTE 700222 Rev. 9/06

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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5084375

MRN: 002581962
Date Exam Completed: 11/11/2007 01:41
Last Update: 11/11/2007

EXAMINATION: CHEST, 11/11/07 01:41:00

ACCESSION NUMBER: 5084375

INDICATION: male s/p crane on head and foot, with AMS

COMPARISON: 11/10/07

FINDINGS: Single frontal radiograph of the chest demonstrates stable support lines and tubes. Stable cardiomediastinal silhouette. There is left basilar opacity likely atelectasis and pleural effusion, unchanged from prior study. There is no evidence of focal air space disease or pneumothorax. Visualized portions of the bony thorax demonstrate right clavicular fracture, unchanged

IMPRESSION:

1. No significant interval change
I have reviewed the images and agree with the findings in this report.

History: male s/p crane on head and foot, with AMS

Technologist: WES LINEBERRY
Interpreter 1: UWE SCHOEPF
Interpreter 2: MELISSA PICCARD
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: JOSEPH SCHOEPF
Date Authenticated: 11/11/2007

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:40 AM
Printed by: LINCOLN, COURTNEY

Transcribed by: Tech IntTalk

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NOV 11 2007

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 1 of 12

(STAMP PLATE)

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

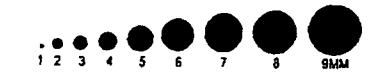
EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # _____





TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PEWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN / SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL	EYES
08	37.1	106	- 18		127	91					96			0 3	4	4	B	B	5	V	2
09		118	- 16		124 92	86					96										
10		105	- 16		119 92	88					95										
11		102	- 16		122 94	90					96										
12	37.8	103	- 16		126	89					96			0 3	4	4	B	B	5	V	2
13		109	- 16		124 95	90					97										
14		105	- 16		120 92	87					97										
15		105	- 16		131 92	88					97										
16	37.6	106	- 16		130 94	91					97			0 3	4	4	B	B	5	V	2
17		97	- 16		118 84	82					94										
18		93	- 16		138 96	96					95										
19		93	- 16		140 96	96					96										
20	37.5	91	- 16		132 91	7					95		20ml Dextrose	VDH 3	4	4	B	B	5	E 4	T 3
21		102	- 16		140 95	8					95										
22		104	- 16		122 90	7					95										
23		110	- 16		127 87	8					97										
24	37.6	120	- 16		136 94	9					100			VDH 3	4	4	B	B	5	E 4	T 4
01		137	- 16		130 81	5					94			VDH 5							
02		129	- 16		105 66	5					93		1L NS Bolus								
03		117	- 16		124 84	7					95										
04	37.4	116	- 16		142 88	9					95		1L NS Bolus Stopped Ad Lib	APP 3	4	4	B	B	5	E 4	T 3
05		101	- 16		140 96	8					98										
06		120	- 14		124 84	8					99										
07		102	- 18		114	11					100										

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 12 of 12

PROGRESS NOTES NOV 11 2007

P:490943644 DOB:01/01/1951 L M
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HECTOR
Adm:11/01/07 M:2581962

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

IV SOLUTIONS / ADDITIVES

TIME	Dilaudid (5mg/100cc)	Neurol (1mg/1cc)	Ativan (4mg/4cc)	Insulin (250units/250cc)	Bolus	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	1	10	1	1			Promote		70	100	100
09	2	10	2	2					70	87	188
10	3	10	3	3					70	87	275
11	4	10	4	4					70	95	371
12	5	10	5	5			flush	30	70	119	49
13	6	10	6	6					70	89	588
14	7	10	7	7					70	131	719
15	8	10	8	8					70	83	802
16	9	10	9	9					70	89	891
17	10	10	10	10					70	86	977
18	11	10	11	11				30	70	114	1091
19	12	10	12	12				40	70	96	1188
20	13	10	13	13					70	97	1285
21	14	10	14	14					70	82	1367
22	15	10	15	15					70	144	1511
23	16	10	16	16					70	86	1597
24	17	10	17	17				30	70	121	1718
01	18	10	18	18				40	70	91	1809
02	19	10	19	19	1000				70	80	1889
03	20	10	20	20	1000				70	88	1977
04	21	10	21	21					70	109	2086
05	22	10	22	22					70	92	2178
06	23	10	23	23					70	167	2345
07	24	10	24	24					70	88	2433

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

1730 Addressed Call of Pt. Report received Assessment Completed & Note Made Care of 1730 & Charge note. 1120 & Charge note 1339 & Charges noted 530 Pt Bathed Linen Changed 1730 No Charges Noted 1900 Report given to On Coming RN 2030 Assumed Care. Pt. Sedated but responds to Voice & Noxious Stimuli. Pt Able to FC's on (L) Suede & MAE's. Opens eyes to Voice Stimuli. CVL Flushed & Patent. Initiated Gtt infusing at 15mg/hr Ativan @ 1mg/hr. & Versed infusing per protocol. Pt's VS's Stable, Vent Settings checked & verified per MD order. Ø S/Sx of Acute Event. Monitor & Alarms enabled. Assessment Complete. Pt's (R) Lower Extremity & necrotic digits, Rims intact & Palpable Pedal pulses 0120 Ø Visits @ this hour. Pt. Remains Stable. 0345 Ø Diu Status, Condition remains Stable. 0100 Pt's HR 138-140's, Febrile 38.8, BP 70/40's CVP 3. MD notified 0130 Orders for 1L Fluid bolus initiated, 0300 Pt's hemodynamic slowly resolving, remains tachy & Febrile 0345 Liter #2 given per MD Order. Will continue to monitor accordingly. 0700 Report given to ANRN Shyman Pt. Remains Stable & tolerating CPAP. Pt. Left Attended to.

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STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS								BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY		STOOL	EMESIS	OG/NG	RESID										
08	450	450	450				0										
09	575	125	125														
10	675	100	100														
11	775	100	100														
12	825	50	50				10										
13	925	100	100														
14	975	50	50														
15	1025	50	50														
16	1100	75	75				10										
17	1200	100	100														
18	1300	100	100														
19																	
20	1700	400	400				0										
21	1820	120	120														
22	1895	75	75														
23	1975	80	80														
24	2050	75	75				0										
01	2100	50	50														
02	2175	75	75														
03	2255	80	80														
04	2335	80	80				0										
05	2375	40	40														
06	2410	35	35														
07	2450	40	40														

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

page 10 of 12

SAFETY

- ☑ Hospital ID band on ☐ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position ☑ Bed brakes on ☑ Bed alarms on
- ☑ Bed heel pressure relief ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☑ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status ☐ Violent behavior
  - ☐ History of falls ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances ☐ Other _____
- ○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:				
TOTAL POINTS:		☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					
TRACH CARE					
BATH					
FOLEY / PERI CARE					
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE					
SKIN CARE					
PEG SITE CARE					
TYPE OF DIET					
% EATEN					
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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* N R S R E C R D *

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

page 4 of 12

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

Bre Alb 28.1

	VENTILATION						BLOOD GASES				HEMATOLOGY					CHEMISTRY							
TYPE O2 DEL	MODE RATE	FiO2 TV	PEEP PS	CPAP PP	MIN VENT		AAV PH	PO2 PCO2	HCO3 O2SAT		HCT HGB	WBC RBC	PT PTT	PLT INR		NA K	CL CO2	GLUC BUN	CREAT CA	MG PHOS		FSBS	
																							08
																							09
																							10
																							11
																							12
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																							07

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
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HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at introducer
A					
P					

Arterial line Date inserted: 11/16/07

	Appearance	Location	Dressing	Calibrated Time
A	S	R rad	D+I	0800
P	S	R rad	D+I	0800

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing
A			
P			

Line #1 Type: R IJ 8Fr CVP Triple lumen Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	R IJ	S	D+I	+
P	R IJ	S	D+I	+

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

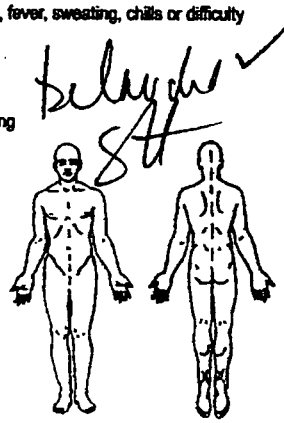
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



○ Any problems identified, implement **Comfort** section of the **POC.**

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

☐ **Psychosocial / Spiritual / Education** A M P N
☐ **Comfort** A M P M
☐ **Neurologic / EENT** A M P M
☐ **Safety** A M P M
☐ **Functional / Musculoskeletal** A M P M
☐ **Skin / Wound** A M P M
☐ **Cardiovascular** A M P M
☐ **Respiratory** A M P M
☐ **Gastrointestinal** A M P M
☐ **Genitourinary** A M P M
☐ **Nutrition** A M P M
☐ **Discharge Planning** A _____ P _____
☐ **Other** _____ A _____ P _____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE TIME

PM SHIFT ASSESSMENT
SIGNATURE TIME

UP# 411230 rev 8/03

NRSRECRD

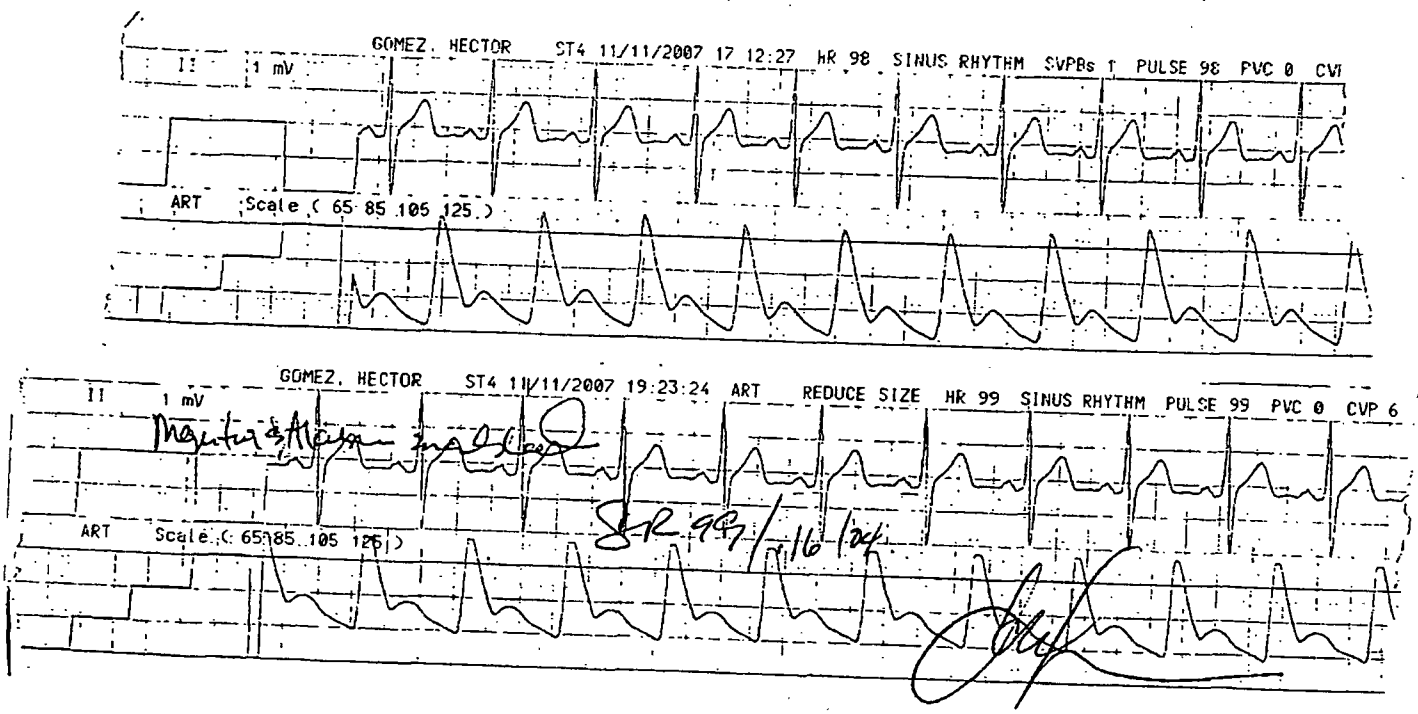
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

page 5 of 12

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THIS SPACE MONITOR STRIPS



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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM _____

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT	✓	✓				
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

○ Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CL=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
○ Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness	✓	✓						
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Site / Type
☐ A ☐ P SCD/foot pump _____
☐ A ☐ P TED _____
☐ A ☐ P Traction _____
☐ A ☐ P Cast/splint _____
☐ A ☐ P External fixator _____
☐ A ☐ P Other _____

Speech
☐ A ☐ P Slurred ☐ A ☐ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin impairments Location
☐ A ☐ P Surgical incision _____
dressing type/appearance _____
☐ A ☐ P Drain _____
☐ A ☐ P Drain _____
☐ A ☐ P Wound _____
dressing type/appearance _____
☐ A ☐ P Other _____
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

○ Any problems identified implement **Skin/Wound** section of the **POC.**

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

page 6 of 12

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	✓ Th, Tan											
HOB>30 degrees unless contraindicated							30°	30°	30°	30°	30°	30°
A line site ✓							✓	✓	✓	✓	✓	✓
IV site ✓							✓	✓	✓	✓	✓	✓
Chest tube patent ✓	N/A						N/A					
NG/OG place ✓							✓					
Mouth care							✓	✓	✓	✓	✓	✓
Turn / Passive ROM							✓	✓	✓	✓	✓	✓
Side Rails							X2	X2	X2	X2	X2	X2
Incen. Spir./ deep breathe							✓	✓	✓	✓	✓	✓
Alarms on / Assessment reviewed							✓	✓	✓	✓	✓	✓

UP#41230 rev 8/03

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(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☐ A ☐ P *Chemical paralysis/sedation*

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	+	+	+	+
P				

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:						
	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☐ A ☐ P Cervical collar

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☐ A ☐ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

If Any problems identified, implement **Neurologic / EENT** section of the **POC**.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐ A ☐ P Arrhythmia SR-Stable

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P *S4*

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A					
P	+	+	+	+	✓

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P	D	D	D	D	

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

If Any problems identified, implement **Cardiovascular** section of the **POC**.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O2 requirements.

☐ A ☐ P: Suction functioning

☐ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P *Accessory muscle use*

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A					
P					

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A				
P	ETT	7.0		

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

If Any problems identified, implement **Respiratory** section of the **POC**.

PROGRECORD

MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

P:490943644 DOB:01/01/1951 L M GOMEZ

P:490943644 DOB:01/01/1951 L M GOMEZ

ATTENDING PHYSICIAN NOTE

MRN: HECTOR Adm:11/01/07 M:2581962

NAME:

Date: 11/11 Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to

Upon personally questioning the patient, I can confirm that the following are the key history factors:

10+ days of 3/4 CHF and foot injury. Cc resp failure

Physical Examination: Pulse: 103 BP: 114/76 Resp Rate: 16 T: 37.8 Input: 2701 Output: 2271

Neuro: sedated, RL in splint

Eyes: PERRL

ENT: ET, OG

CV: RRR

Resp: BS ↓ LLL, + PSVG 18 500 5 TP mobilize

GI/Nutr: BS+, soft NT ND 7.43 36 77 24 96 titrated

CU/Renal: UOP adequate

MuscSkel: MAE x4, splint on RLE attempt

Skin: Intact, no new breakdown

Psych: Appropriate

Other: H 34 317 ABG 7.52 K 3.4 CO2 28

☑ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.

☐ I have reviewed the results radiographs as documented in the resident's note.

☑ I have personally reviewed pertinent X-ray examinations.

☐ I have personally reviewed the results of additional medical testing and monitor output.

☑ I have personally discussed the case with Dr. Stokes

Diagnoses/Problems

1. resp failure - trach/vent dep PS, possible — ☐New ☐Improved ☐Unchanged ☐Worsening
2. stroke w/ memory — ☐New ☐Improved ☐Unchanged ☐Worsening
3. pneumonia - cat meropenem D5/8 — ☐New ☐Improved ☐Unchanged ☐Worsening
4. — ☐New ☐Improved ☐Unchanged ☐Worsening
5. hyperglycemia - on insulin drip — ☐New ☐Improved ☐Unchanged ☐Worsening
6. — ☐New ☐Improved ☐Unchanged ☐Worsening

Management Options/Recommendations

1. malnutrition (albumin) TF @ goal, ↑ prealbumin
2.
3.
4. Pt is doing well, possible SBT tomorrow
5.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☑High

☐ Pt is critically ill/injured. I spent 35 minutes providing critical care to this patient.

Overall Condition: ☑Critical ☐Serious ☐Fair ☐Good

Signature Date 11/11

UMA #19100-13 revised 11/06

MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY
Patient Name: GOMEZ-FRAGOSO, HECTOR
MRN: 002581962
Patcom: 103530309
Admitted: 12/12/2007
Discharged: 12/15/2007
Service: Ortopedic Surgery
Attending: KEITH D MERRILL, MD

Referring:

CHIEF COMPLAINT: Foot pain.

HISTORY OF PRESENT ILLNESS: This is a young gentleman who presents after previously having a TMA secondary to a crush injury who presents with a wound dehiscence. Patient came into clinic today with kind-of foul-smelling open wound. Patient denies any fevers, chills, nausea, vomiting, or diarrhea, however.

PAST MEDICAL HISTORY: Patient had a a subdural hematoma as well as some bilateral frontal contusions with his traumatic injury.

PAST SURGICAL HISTORY: Right 2 through 5 transmetatarsal amputation.

SOCIAL HISTORY: The patient denies smoking.

CURRENT MEDICATIONS: Oxycodone.

MEDICAL ALLERGIES: No known drug allergies.

PHYSICAL EXAMINATION: He is alert and oriented in no acute distress. Skin is unremarkable. Lungs are clear. Heart is regular. Abdomen is soft, nondistended, nontender. Foot wound is completely dehisced. It is kind-of foul-smelling. There is fibrinous exudate at this point.

HOSPITAL COURSE: Patient was admitted to MUSC Hospital on 12/12/2007 to the orthopedic surgery service for a diagnosis of wound dehiscence from a previously transmetatarsal amputation. Patient was started on IV antibiotics. On 12/14, patient was consented and taken down to the operating room for an irrigation and debridement of the wound under anesthesia. For full details of this operation, please refer to operative report as dictated. Patient tolerated the procedure quite well. Postoperatively he was taken to the PACU and then to the floor in stable condition. His diet was advanced as tolerated. His pain was controlled on p.o. pain medications. Since the nature of the procedure was relatively minor, the patient did quite well. We felt that he was medically safe for discharge on day of procedure. At time of discharge patient was afebrile. His vital signs were stable. His pain was controlled. His wound was packed and dressed. He was instructed to leave this on until he followed up with Orthopedics in 1 week. Patient's weightbearing status was nonweightbearing to that lower extremity.

DISCHARGE DIAGNOSIS(ES): Wound dehiscence from previous transmetatarsal amputation.

DISCHARGE MEDICATIONS:
1. Oxycodone 5-10 p.o. q.4 hours p.r.n. for pain.
2. Colace 100 mg p.o. b.i.d.
3. Bactrim double strength 160/800 mg p.o. b.i.d.

PATIENT DISPOSITION: Patient is discharged to home in stable

condition. Patient is to follow up with McClennan-Banks Clinic next Wednesday. Patient's weightbearing status is nonweightbearing, right lower extremity. Patient is instructed to do no driving while on pain medications. He may have a regular diet. He is to call for any fevers greater than 101.5, any excessive pain, redness, swelling, bleeding, increased drainage from incision site, any opening or pulling apart of incisions, any other problems, questions, and/or pain medication renewal. Patient may shower if he is able to keep the wound and dressings dry. He is instructed on no soaking wound for 3-4 weeks. Patient is not to change his dressing until followup appointment.

Dictated by: Mark Perna, MD

_____
Mark Perna, MD

_____
KEITH D MERRILL, MD
Attending

747043 / 30028 / 36495
JOB: 375460
DD: 12/14/07 01:51 PM
DT: 12/18/07 09:28 AM

Additional CC:_____

DOCID: 18233747043

Edited By ANN SHULER on 12-20-2007 at 03:50:28 PM
Edited By MARK PERNA on 01-14-2008 at 07:52:13 AM
Electronically signed by KEITH MERRILL, on 01-30-2008 at 04:31:59 PM

MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 103530309
Date of Surgery: 12/14/2007
Surgeon: Keith D. Merrill, MD
Assistant(s): Huey Ahn

PREOPERATIVE DIAGNOSIS: Wound dehiscence right foot.

POSTOPERATIVE DIAGNOSIS: Wound dehiscence right foot.

PROCEDURES: Irrigation and debridement and partial wound closure of the right foot. CPT code is 28003.

INDICATIONS FOR PROCEDURE: The patient is a young male who had a crane fall on his foot. He underwent amputation of the toes, was seen in clinic the other day with increased drainage, swelling, and wound dehiscence.

DESCRIPTION OF PROCEDURE: After general anesthesia, his right lower extremity was prepped and draped in a sterile fashion. Curette was used to debride some of the soft tissue from out of the dehisced wound. Sutures were removed. The remaining tissue actually looked quite good and after debridement with a rongeur, the plantar pad was pulled up slightly and each end was closed with approximately 3-4 sutures. This left a gap in the middle a couple of centimeters wide and probably 4 cm long. This was dressed with gauze. A culture and sensitivity had been done intraoperatively.

The patient was taken to the recovery room after dressing was applied in good condition. Wet-to-dry dressings will be used.

Dictated by: Keith D. Merrill, MD

Keith D. Merrill, MD
Surgeon

738151 / 33871 /
JOB: 375334
DD: 12/14/07 07:50 AM
DT: 12/16/07 08:31 PM

Additional CC:_____

DOCID: 18233738151

Electronically signed by KEITH MERRILL, on 01-30-2008 at 04:31:55 PM

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5084726

MRN: 002581962
Date Exam Completed: 11/12/2007 06:46
Last Update: 11/12/2007

Chest

Accession Number: 5084726

Indication: s/p skull fx, intubated

Comparison: 11 11 07

Findings: Single frontal radiograph of the chest demonstrates unchanged position endotracheal tube tip well above carina , right central venous catheter tip over superior vena cava , nasogastric tube over stomach unchanged since prior exam . The size and contour of the cardiomediastinal silhouette and hilum are unchanged . Lungs again demonstrate patchy air space disease in the bases left worse than right but no , pneumothorax, or pleural effusion . The bones are unchanged with fracture of the right clavicle

Impression:
No significant interval change.

History: s/p skull fx, intubated

Technologist: ELMON WATSON
Interpreter 1: STEPHEN SCHABEL
Interpreter 2:
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: STEPHEN SCHABEL
Date Authenticated: 11/12/2007

Transcribed by: Tech IntTalk

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:40 AM
Printed by: LINCOLN, COURTNEY

* N R S R E C R D *

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

(STAMP PLATE)

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # _____

APP = Assume Pain Present

1 2 3 4 5 6 7 8 SMM

TIME	TEMP	PULSE	SPON VENT RESP	CUFF BP	A-LINE BP	MAP	CVP	PA	CO CI	SVR	S_vO_2	ICP HI LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS REACTION R	PUPILS SIZE L	PUPILS REACTION L	MOTOR	VERBAL EYES
08	37.7	106	15		160/	107					100			0	3	4	B	4	B	5	V 4
09		107	13		154/	101					99										
10		111	19		164/	104					99										
11		110	17		154/	107					98										
12	37.9	134	27		159/	102					98			0	3	4	B	4	B	5	V 4
13		124	17		138/	90					95										
14		116	16		132/	91					97										
15		127	28		144/	96					97										
16	38.4	123	23		152/	83					95			0	3	4	B	4	B	5	V 4
17		121	22		143/	96					97										
18		114	20		138/	88					97										
19		120	22		148/	95					96										
20	37.9	119	22		117/	85					96			0	5	4	B	4	B	5	V 4
21		112	27		101/	95					97										
22		91	25		114/	81					96										
23		113	28		128/	91					94										
24	37.6	98	14		122/	90					92			0	4	4	B	4	B	5	V 4
01		117	22		125/	90					97										
02		112	20		127/	87					98										
03		94	18		123/	98					97										
04	37.3	103	14		118/	79					96			0	5	5	B	5	B	5	V 4
05		110	20		123/	85					96										
06		107	22		121/	73					90										
07		107	22		125/	88					95										

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

page 2 of 12

TIME	IV SOLUTIONS / ADDITIVES	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	Maint-Mud (500 ml/100 ml/hr) + Cefazolin (2 grams/100 ml/hr) + Insulin (2 units/1 ml/hr)					17.3	17.3
09						16.9	34.2
10						14	48.2
11						16.5	64.7
12						15.8	80.5
13						15.8	96.3
14						15.2	111.5
15						17.5	129
16						15.8	143.8
17						15.8	159.6
18						16.5	176.1
19						14	190.1
20						16	206
21						13	219
22						15	234
23						14	248
24						14	262
01						13	275
02						13	288
03						12	300
04						13	313
05						12	325
06						12	337
07						12	349

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007
page 11 of 12

(STAMP PLATE)

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0730 Assumed care of pt. Report received. Assessment complete & notes reviewed. Pt alert & oriented. Drips stopped. Pt on CPAP. 0930 Q Changes made. 1130 Q Changes made. 1330 Q Changes made. 1530 Pt bathed/changed. Changes done. 1730 Q Changes made. 1900 Report given to oncoming nurse.

1900 Report received from AM shift. Pt alert & oriented. 1945 - pt assessed. pt resting, follows commands. pt oriented x 3. needs frequent turning & repositioning. 2300 - pt continues to be restless in bed. VS stable. 0130 pt has had BM. pt cooperative. 0300 - AM labs drawn. pt continues to be restless in bed. VS stable. 0500 - Q changes. 0530 - pt attempted to pull out foley. restraints secured and re-situated in bed. 0715 - Report given to oncoming shift.

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS								BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY		STOOL	EMESIS	OG/NG	RESID										
08	50	50	50														
09	150	100	100														
10	500	250	250														
11	625	125	125														
12	815	190	190														
13	1175	360	360														
14	1500	325	325														
15	1600	100	100														
16	1850	250	250														
17	1975	125	125														
18	2025	50	50														
19	2075	50	50														
20	2190	115	115			1000 1000											
21	2415	225	225														
22	2465	50	50														
23	2580	115	115														
24	2655	75	75														
01	2855	200	200														
02	2935	80	80														
03	2995	60	60														
04	3070	75	75														
05	3130	60	60														
06	3200	70	70			500 1300											
07	3355	155	155														

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☑ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position
- ☑ Bed brakes on
- ☑ Bed alarms on
- ☑ Bed heel pressure relief
- ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☐ High alert medications identified
- ☑ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ Violent behavior
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other _____
- ○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:				
TOTAL POINTS:		☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					
TRACH CARE					
BATH					
FOLEY / PERI CARE					
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE		0730			
SKIN CARE					
PEG SITE CARE					
TYPE OF DIET					
% EATEN					
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES				HEMATOLOGY				CHEMISTRY								
	TYPE C_2DEL	MODE RATE	FiO_2 TV	PEEP PS	CPAP PIP	MIN VENT	A/V PH	PO_2 PCO_2	HCO_3 O_2SAT		HCT HGB	WBC RBC	PT PTT	PLT INR	NA K	CL CO_2	GLUC BUN	CREAT CA	MG PHOS		FSBS	
	100	CPAP 10		5	10																	
08																					91	
09																						
10																					76	
11																					86	
12																					85	
13																					85	
14																					82	
15																					89	
16																					85	
17																						
18																					80	
19																					76	
20																					95 .19	
21																					90 .18	
22																					91 .17	
23																					85 .16	
24																					82 .15	
01																					83 .14	
02																					88 .13	
03							A 7.36	71 36	37 93.9	32 11.3	11.9 35-46	257	148 4	112 28	30 48	6.3 9.6	2.4 9.1				81 .12	
04																					87 .11	
05																					82 .1	
06																					91 .09	
07																					97 .08	

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at introducer
A					
P					

Arterial line Date inserted: 11/01/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	R rad	DC	[illegible]	
P	S	R radial	DI	1945	D/C'd LF, @ D1.0L

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: [illegible] Insert Date: 11/07

	Site	Appearance	Dressing	Blood Return
A	DSC	S	DI	✓
P	DSC	S	DI	✓

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Medicated

Abnormal Findings

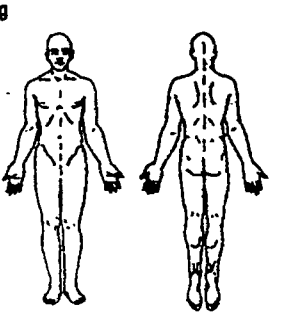
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



○ Any problems identified, implement **Comfort** section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

- ☐ Psychosocial / Spiritual / Education A_____ P M
- ☐ Comfort A_____ P M
- ☐ Neurologic / EENT A_____ P M
- ☐ Safety A_____ P M
- ☐ Functional / Musculoskeletal A_____ P M
- ☐ Skin / Wound A_____ P M
- ☐ Cardiovascular A_____ P M
- ☐ Respiratory A_____ P M
- ☐ Gastrointestinal A_____ P M
- ☐ Genitourinary A_____ P M
- ☐ Nutrition A_____ P_____
- ☐ Discharge Planning A_____ P_____
- ☐ Other _____ A_____ P_____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE [illegible] TIME [illegible]

PM SHIFT ASSESSMENT
SIGNATURE [illegible] TIME 1945

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* N R S R E C R D *

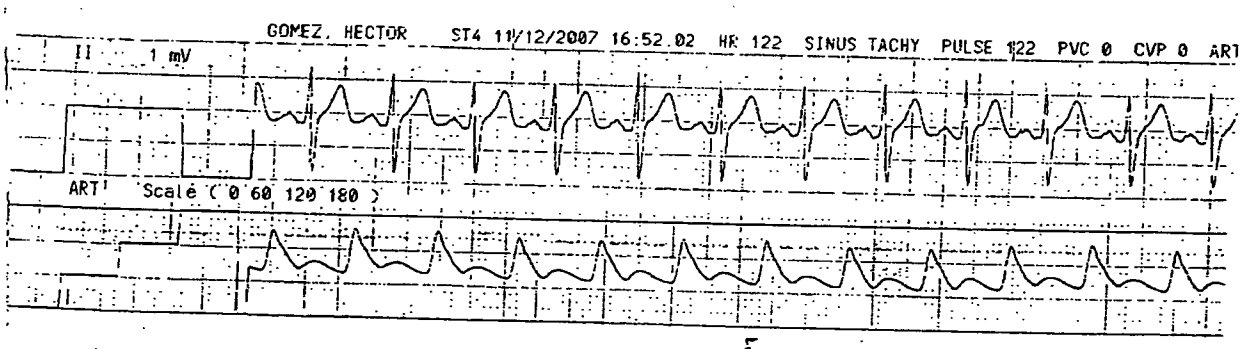
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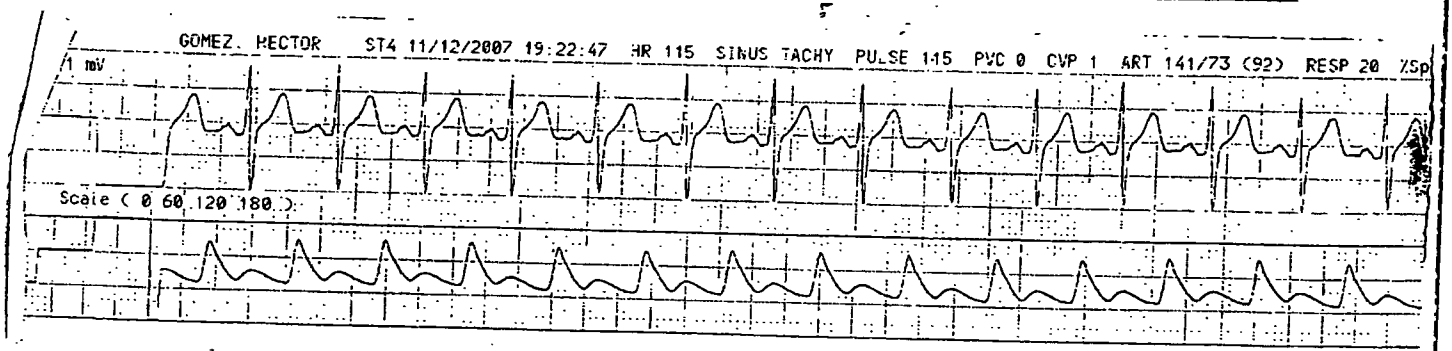
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Adm:11/01/07 M:2581962
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

page 5 of 12

THIS SPACE MONITOR STRIPS





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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM [illegible]

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT	✓	✓	H-C	H-		
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; UF = undigested food

○ Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; Cl=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
○ Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness	✓		✓		✓		✓	
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Site / Type
☐ A ☐ P SCD/foot pump _____
☐ A ☐ P TED _____
☐ A ☐ P Traction _____
☐ A ☐ P Cast/splint _____
☐ A ☐ P External fixator _____
☐ A ☐ P Other _____

Speech
☐ A ☐ P Slurred ☐ A ☐ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin impairments Location
☐ A ☐ P Surgical incision _____
dressing type/appearance _____
☐ A ☐ P Drain _____
☐ A ☐ P Drain _____
☐ A ☐ P Wound Sutures - top
dressing type/appearance Clean
☐ A ☐ P Other _____
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

○ Any problems identified implement **Skin/Wound** section of the **POC.**

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962
(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☑ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	V Th Tn	←				→	Sx Th,Tn	Sx Th,T	Sx Th	Sx Tn,T	Sx Th,T	Sx Th,T
HOB>30 degrees unless contraindicated	SH	←				→	30°	30°	30°	30°	30°	30°
A line site ✓	SH	←				→	~	~	~	~	~	~
IV site ✓	SH	←				→	~	~	~	~	~	~
Chest tube patent ✓	N/A	←				→	NA	NA	NA	NA	NA	NA
NG/OG place ✓	tube	←				→	~	~	~	~	~	~
Mouth care	SH	←				→	~	~	~	~	~	~
Turn / Passive ROM	SH	←				→	~	~	~	~	~	~
Side Rails	SH	←				→	X2	X2	X2	X2	X2	X2
Incen. Spir./ deep breathe	SH	←				→	Vent	Vent	Vent	Vent	Vent	Vent
Alarms on / Assessment reviewed	SH	SH	SH	SH	SH	SH	~	~	~	~	~	~

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 12 2007

page 7 of 12

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☐ A ☐ P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	+1	+1	+1	+1
P	+2	+2	+2	+2

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☐ A ☐ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☐ A ☐ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

○ Any problems identified, implement **Neurologic / EENT** section of the **POC.**

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐ A ☐ P Arrhythmia Sinus tach

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	+1	+1	+1	+1	
P	trace				

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P					

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate A	Rate V	mA A	mA V	Sensitivity A	Sensitivity V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

○ Any problems identified, implement **Cardiovascular** section of the **POC.**

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☐ A ☐ P: Suction functioning

☐ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	WL	WL	WL	WL	WL
P	R	R	R	R	R

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	7.0		22cm
P	ETT	7.0		22cm

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal A	Suction amt or H_2O Seal P	Drainage A	Drainage P	Air Leak A	Air Leak P	SQ emphysema A	SQ emphysema P

○ Any problems identified, implement **Respiratory** section of the **POC.**

UPN 411230 rev 8/03

"PRGRECRD"

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name
MRN
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	ST, CU
11/12	7[st]	Pt trial on PS trials continued. 0 new issues. Pt ~~remained~~ 5. Bolused x1 ~~x~~ for hypotension +2L.
		37.8 37 120:14 159/93 99% PS 5/10/40%
		4417/2450
		Conv WAD, opens eyes, moves LUE, RLE, LLE spontaneously, & FC.
Combivent		HEENT: PERRL/ET in place
Lovenox		Neck: Minerva J in place
Lasix 20 q6h		CV: TTR; & m/c/r.
Morphine		Lungs: CTA(B). ~~&~~ BS.
Ativan c/		Abd: soft, nt, nd(+) bs
Pitavastatin c/		Extrem: RLE: toes 2-5 discolored, 3-5 tips look like they have declared. Hand splint in situ.
		LLE: SCD in place & S/C/E.
		Labs: 14.4/11.1/27/82 8.6 / 2.2 / 3.7 — 3.0/26/0.8 — 9.7 — 16 — 267 — 31 Pre H 28.1
		A/P: 26 y/o hm s/p ICT to head c open skull fx. 1. Pulm: ventilated. PS unusual. Few desaturations. Will plan to try to extubate today. 2- CV: 0 issues. Remains tachy. Possibly from being fluid down. Will hold labs for now. 3. Extrem: RLE shows signs of vascular deficiency to toes 2-5. Other ampe. Follow closely. 4. ID: on vanco. Afebrile. WBC down to 9.7 from 11.

prgrecrd1

OTE 700222 Rev. 9/06

PRGRECRD

MUSC
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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Patient Name
MRN Adm:11/01/07 M:2581962

STAMP PLATE AREA

Prohibited abbreviations:

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/12/07		ORTHO
	9:52am	will eventually need amputation of lesser toes on right and closure of wound when pt more stable! Hurtbach
11/12/7		ORTHO
	145pm	Status of toes noted. Severe cachexia 2o (R) foot c ischemia of Toes 2-4. Pt now has dry gangrene c necrotic Toes 2-4 from DoP → Dpc. Proximal tissue remains ischemic but not necrotic and still has perfusion upto proximal phalanges. Hallux is well perfused c healthy skin throughout. I agree c note above per Dr. Hurtbach that once his condition improves & the toe tissue fully declares, he will need amputation of necrotic digits. In meantime, keep wounds/tissue clean & dry, prevent infection/wet gangrene. Will follow and schedule procedure at appropriate time. Jr H

prgrecrd1

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INTERDISCIPLINARY PROGRESS NOTES

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR

ATTENDING PHYSICIAN NOTE

MRN: Adm:11/01/07 M:2581962

NAME:

Date: 11/12 Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to

Upon personally questioning the patient, I can confirm that the following are the key history factors:

RD 27 yo ♂ s/p Skull fx c- vpl failure

Physical Examination: Pulse: 114 BP: 166/82 Resp Rate: 20 T: 37.8 (37.7) Input: 4.4 Output: 2.4

Neuro: Agitated, PTC
Eyes: PERRLA
ENT: MMM. pink CT. OG
CV: RRR
Resp: Vent AC 16
GI/Nutr: CTA B
CU/Renal: BS+ TBSA NT/ND
MuscSkel: MAE
Skin: Necrosis of L distal 3 toes RLE
Psych: N/A
Other:

7a HR 110 134 24 KVO
+ PS 10 x TF 70 abrupt - off propofol
144 111 27 8.6 Chemwell
3.8 26 28 82 22 Lactate
3.7
10 31 267

☐ I have reviewed the results of pertinent laboratory tests as documented in the resident's note. Pneumo 28
☐ I have reviewed the results radiographs as documented in the resident's note.
☐ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☐ I have personally discussed the case with Dr. Hardock meropen DC/8

Diagnoses/Problems

1. hypotension stop dilantin, mild rebleed — ☐New ☐Improved ☐ Unchanged ☐Worsening
2. possible seizure — ☐New ☐Improved ☐ Unchanged ☐Worsening
3. pneumonia - intubated - cont meropen DC/8 — ☐New ☐Improved ☐ Unchanged ☐Worsening
4. — ☐New ☐Improved ☐ Unchanged ☐Worsening
5. resp failure - ETT intact today — ☐New ☐Improved ☐ Unchanged ☐Worsening
6. — ☐New ☐Improved ☐ Unchanged ☐Worsening

Management Options/Recommendations

1. malnutrition - RE TF - when pt is awake
2.
3.
4. Extubate today. Start regular diet.
5.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☒High
☐ Pt is critically ill/injured. I spent 35 minutes providing critical care to this patient.
Overall Condition: ☒Critical ☐Serious ☐Fair ☐Good

C Mansell Signature Date

UMA #19100-13 revised 11/06

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Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5085564

MRN: 002581962
Date Exam Completed: 11/13/2007 04:36
Last Update: 11/13/2007

EXAMINATION: PORTABLE CHEST 11/13/07 04:36:00

ACCESSION NUMBER: 5085564

INDICATION: OPEN SKULL FRACTURE, RESPIRATORY FAILURE

COMPARISON: CXR 11/12/07

FINDINGS: Single frontal radiograph of the chest demonstrates no interval change in position of endotracheal tube or left central venous catheter. Interval advancement of enteric tube with tip now likely trans-pyloric. The size and contour of the cardiomediastinal silhouette and hilum are stable. Lungs and pleura show left lower lobe atelectasis or effusion. Osseous structures are unchanged.

IMPRESSION:

1. No significant interval change in left lower lobe atelectasis and/or effusion.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW

I have reviewed the images and agree with the findings in this report.

History: 27 yo hm sp open skull fracture

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Printed: 01/07/2008 10:39 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5085564

MRN: 002581962
Date Exam Completed: 11/13/2007 04:36
Last Update: 11/13/2007

Technologist: GENE BRUNSON
Interpreter 1: JAMES RAVENEL
Interpreter 2: MARQUES BRADSHAW
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/13/2007

Transcribed by: Tech IntTalk

MUSC
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Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5086967

MRN: 002581962
Date Exam Completed: 11/13/2007 17:25
Last Update: 11/13/2007

EXAMINATION: CHEST 11/13/07 17:25:00

ACCESSION NUMBER: 5086967

INDICATION: Crane to head with CHI and decreased oxygen saturation

COMPARISON: 11/13/07 0425 hrs

FINDINGS: AP portable view. Support line and tubes remain in satisfactory position. Mediastinal and hilar contours and cardiac silhouette are stable. Bibasilar atelectasis and small effusions

IMPRESSION: Stable chest

VOICE DICTATED BY: Dr. JAMES RAVENEL

History: Crane to head with CHI

Technologist: DAVID DECHANT
Interpreter 1: JAMES RAVENEL
Interpreter 2:
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/13/2007

Transcribed by: Tech IntTalk

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Printed: 01/07/2008 10:39 AM
Printed by: LINCOLN, COURTNEY

* N R S R E C R D *

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

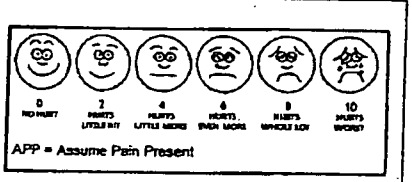
VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

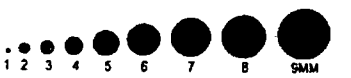
EYES
4 Spontaneous
3 Open to speech/Verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #





TIME	TEMP	PULSE	SPON VENT RESP	CUFF BP	A-LINE BP	MAP PCWP	CVP	PA	CO CI	SVR	S_vO_2	ICP HI LOW	DAILY WEIGHT 152 / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS REACTION R	PUPILS REACTION L	MOTOR R	MOTOR L	VERBAL EYES
08	99.8	106	25		139/97	109	9				95		0845: PT Extubated	0	5	5	5	5	5	ET 4
09		115	25	132/84	130/84	101	3				95		CC rounds							
10		119	25		125/80	100	4				95									
11		114	25	134/67	120/72	98	7				96									
12	100.3	117	30	134/74	134/80	103	8				95		CC rounds	0	4	5	5	5	5	ET 4
13		124	27	129/72	124/79	91	4				96		1320: Art line pulled out by PT							
14		122	25	128/83		84	9				95									
15		124	31	146/90		106	13				95									
16	100.5	118	4 16	96/62			5				93		1550: Intubated							
17	99.1	120	10 16	114/71		82	10				100		OG Placed CC rounds	0 3	5	5	5	1	1	ET 1
18		102	1 18	115/70	119/80	91	5				97		1810: (R) Rem A-line							
19		100	16	116/71	116/77	91	5				92									
20	99.1	102	0 16		114/76	88	5				96		2105 ABG: 10 Sxn	0 3	5	5	5	5	5	T 2
21		112	16		113/75	90	4				96									
22		107	16		110/74	83	5				95									
23		109	16		IN/	89	4				96									
24	99.1	108	16		12[illegible]	88	5				98			0 3	5	5	5	5	5	T 4
01		102	16		113/77	88	5				97		Bath, Linens, Mouth I Δ							
02		106	16		136/64	103	7				96		Labs, ABG							
03		104	16		127/[illegible]	87	6				97		2315 ABG (20mm P)							
04	98.6	92	16		116/78	88	9				99			0 5	5	5	5	5	5	T 4
05		98	16		120/80	94	9				99									
06		94	16		117/75	94	8				99									
07		86	16		135/71	95	9				100									

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24 HOUR CRITICAL CARE PATIENT RECORD Date ~~NOV 1 8 2007~~
page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

1x1 paged. Also not at propofol infusing and TFs on hold. NO as/ new orders. Decised. SH
2150 Dr Ayad assessed patient at bedside, orders for MIUF recieved. MD Aware of blood in urine. SH
1720 Report to oncoming RN. SH

Signature / Shift	Initials	Signature / Shift	Initials
Matt Tuberville Am Shift	MT		
Stanie Hartmann 7W19-730	SH		

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007

page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	NS c 20 meq KCl/L	Insulin	IV Meds	Protonix 10mg/ml	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	10 / 10	2.5 / 3				NPO			13	13
09	10 / 20	1.2 / 5							12	25
10	10 / 30	3 / 8							13	38
11	10 / 40	2.6 / 11							13	51
12	10 / 50	2.6 / 14							13	64
13	10 / 60	2.6 / 17							13	77
14	10 / 70	2.6 / 20							13	90
15	10 / 80	2.6 / 23	50 / 50						53	143
16	10 / 90	2.5 / 26							13	156
17	10 / 100	3.7 / 29		4.8 / 5					8	164
18	10 / 110	2.5 / 32		4.8 / 10					18	182
19	10 / 120	1.6 / 34		4.8 / 15					17	199
20	10 / 130	2.1 / 36		4.8 / 20					17	216
21	10 / 140	1.4 / 37		4.8 / 25					16	232
22	10 / 150	0.7 / 38	50 / 100	4.8 / 30					66	298
23	10 / 160	0.6 / 39	—	4.8 / 40					66	364
24	10 / 170	1 / 41		4.8 / 45					16	380
Δ 01	100 / 270	0.8 / 41		4.8 / 50					106	486
02	100 / 370	0.8 / 42		4.8 / 55					106	592
03	100 / 470	1 / 43		4.8 / 60					106	698
04	100 / 570	1.2 / 45		4.8 / 65					107	805
05	100 / 670	0.8 / 46		4.8 / 70					106	911
06	100 / 770	0.9 / 47	50 / 150	4.8 / 75					86	997
07	101 / 870	1 / 48	—	4.8 / 80					176	1173

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007
page 11 of 12 ..

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0715 Report Recieved from Night Nurse, Chart Reviewed. MW 0730 Physical Assessment Performed and documented Per Flowsheet. PT Awake but Not following commands, Dr. Sarki evaluated PT's understanding of Commands. See Flow Sheet for more details, Also for Vitals & I+O. 0815 orders to Extubate PT. PT Extubated without Difficulty, PT Placed on 5L NC, Lung sounds Coarse B/L & Diminished bases, O_2 Sats > 94% on 5L. PT Able To Clear secreations, but Will Not Cough With Commands. See Flowsheet for Vitals. CC Team @ Bedside MW 0900 CC Rounds. MW 1200 CC Rounds MW PT's Back side of Head Bleeding, Small amount of Hemah Blood Noted & Some Forehead Swelling Noted. Dr. Vesel Made Aware 1215 Swelling and Bleeding Noted @ Back side of Head with Increasing Forehead swelling and Bleeding. CC Team Made Aware. Pressure dressing Applied by CC Team to Top and Back side of Head MW 1320 Cranial Dressing D/I without Bleeding Noted @ This Time. PT Neuro Status unchanged. PT Pulled out (R) And Art Line, Pressure Dressing Applied and CC Team Made Aware MW 1530 HR T 130's (Sinus), PT unResponsive. Dr. Blown Informed of PT Condition. O_2 Sats 88% PT NT Suctioned Thin Tan secretions & some Bloody secreations Aspirated. O_2 Sats Remain 90%. on 50% Venti Mask. RR 30, PT Remains unResponsive ABG Sent, orders To Intubate PT. MW 1530 PT Intubated by Anesthesia Team & 8.0 ET Tube @ 24 @ Teeth Line. Lung sounds Coarse Bilateraly, O_2 Sats Elevated to 98% 1700 OG Tube Placed, (+) Air Bolus Noted. Placed to LC Suction, Blown Drainage Noted. MW 1800 (A) Fem A-line Placed By N. Stones. PT Tolerated Well MW 1930 Recieved report. Assumed care. Assessed patient. SIT 2100 ABG results recieved. Notified RT. Notified MD via

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page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

TIME	OUTPUT CUM	OUTPUT HOURLY	URINE Foley	GASTRIC STOOL	GASTRIC EMESIS	GASTRIC NG/NG	GASTRIC RESID	CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
08	75	75	75/75							
09	150	75	125/200			1950/1950				
10	525	75	75/275							
11	675	150	150/425							
12	750	75	75/500							
13	825	75	75/575							
14	885	60	60/635							
15	985	100	100/735							
16	1060	75	75/810			2350/2350				
17	1110	50	50/860							
18	1510	400	50/910			600/600				
19	1560	50	50/960							
20	1610	50	50/1010							
21	1675	65	65/1075							
22	1700	125	125/1200							
23	1750	50	50/1250							
24	1800	50	50/1300							
01	1850	50	50/1350							
02	1900	50	50/1400							
03	2000	100	100/1500							
04	2050	50	50/1550							
05	2100	50	50/1600							
06	2175	75	75/1675							
07	2725	550	50/1725			500/1100				

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007

page 10 of 12

SAFETY

- ☑ Hospital ID band on ☐ Allergy band on
- ☐ Call system accessible
- ☐ Bed in low position ☐ Bed brakes on ☐ Bed alarms on
- ☐ Bed heel pressure relief ☐ On ☐ Off reason: _____
- ☐ IV solutions verified
- ☐ IV tubing/bag dated
- ☐ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status ☐ Violent behavior
  - ☐ History of falls ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances ☐ Other _____
- ○ Any risk criteria identified, implement the **Safety** section of the **POC.**

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/dx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:	0	2	0	0
TOTAL POINTS:	8	☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

☑ If score ≥ 6, implement **Safety** section of the **POC.**

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE	0145 MW				
TRACH CARE					
BATH		1400 MW			
FOLEY / PERI CARE	1000 MW	1200 MW	1400 MW		
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE	1200 MW	1400 MW			
SKIN CARE	1000 MW	1400 MW			
PEG SITE CARE					
TYPE OF DIET	NPO				
% EATEN	NPO				
PACING WIRES INSULATED SECURED					
SPECIALTY BED	STCV				

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NRSRECRD

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 3 2007

page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES				HEMATOLOGY					CHEMISTRY									
TYPE O2 DEL	MODE RATE	FIO2 TV	PEEP PS	CPAP PIP	M.N VENT		A/V PH	PO2 PCO2	HCO3 O2SAT		HCT HGB	WBC RBC	PT PTT	PLT INR		NA K	CL CO2	GLUC BUN	CREA CA	MG PHOS		FSBS		
Vent	CPAP	40	5	✓																				08
0845	Placed on 4L NC		10																					09
0947	A						A 7.45	77 36	24.8 41.4															10
																								11
																								12
																								13
						1532	A 7.21	95 53	27.5 51.5															14
Vent	PRVC 16	100 500	5			1680	A 7.41	65 40	26.3 92															15
	T18		T10																					16
																								17
							A 7.52	77 31	25.4 96															18
	VC16 PRVC 16	T12 100 50% R		VC 8.7																				19
V							A 7.46	72 37	25.6 94%															20
																								21
																								22
																								23
			27																					24
																								01
V	PRVC 16	60 50%	12				A 7.48	91 46	28.7 97		34.4 11.4	8.9 3.9		359		3.6	105 25	113 29	0.8	9.1	2.1	3.8		02
							A 7.49	77 36	28.6 96															03
																								04
																								05
																								06
																								07

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line → (A) Fem A line Placed 11-13-07 Date inserted: 11/10/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(A) Rad	D/I	0900	Changed w/c (A) BK
P	S	From D/C'd	D/I	2100	D/C'd by PT (Billed out by AT)

High Dose Heparin catheter Type: Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: GLC Insert Date: 11/2/07

	Site	Appearance	Dressing	Blood Return
A	RSC	S	D/I	+
P	LSC	S	D/I	+

Line #2 Type: Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☑P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy. To reassess

Abnormal Findings

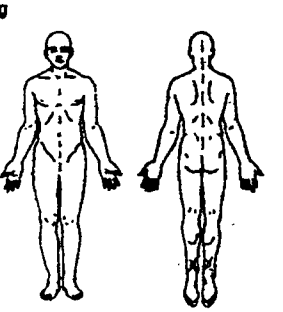
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



○ Any problems identified, implement **Comfort** section of the **POC**.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

- ☑ **Psychosocial / Spiritual / Education** A M P M
- ☑ **Comfort** A M P M
- ☑ **Neurologic / EENT** A M P M
- ☑ **Safety** A M P M
- ☑ **Functional / Musculoskeletal** A M P M
- ☑ **Skin / Wound** A M P M
- ☑ **Cardiovascular** A M P M
- ☑ **Respiratory** A M P M
- ☑ **Gastrointestinal** A M P M
- ☑ **Genitourinary** A M P M
- ☐ **Nutrition** A _____ P _____
- ☐ **Discharge Planning** A _____ P _____
- ☐ **Other** _____ A _____ P _____

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE [signature] TIME 0730

PM SHIFT ASSESSMENT
SIGNATURE [signature] TIME 2100

UP# 411230 rev 8/03

* N R S R E C R D *

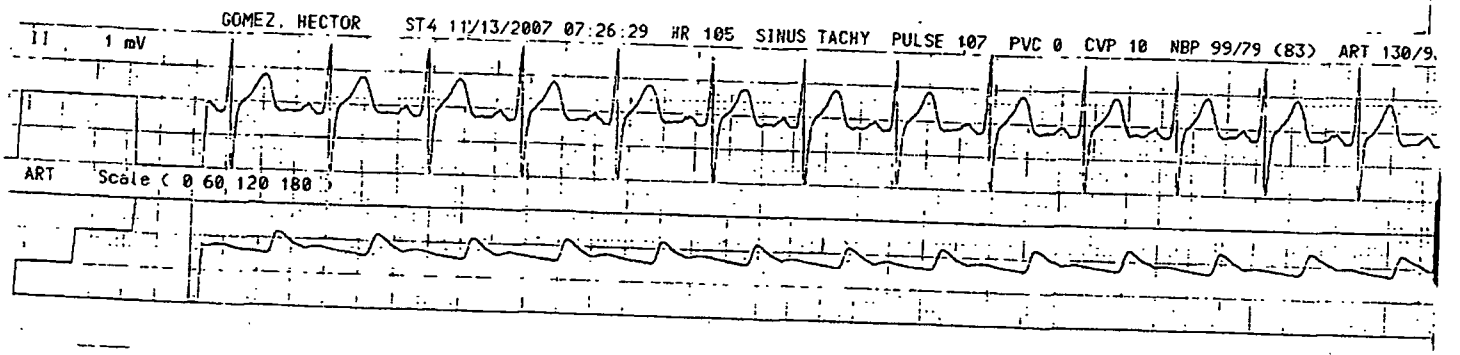
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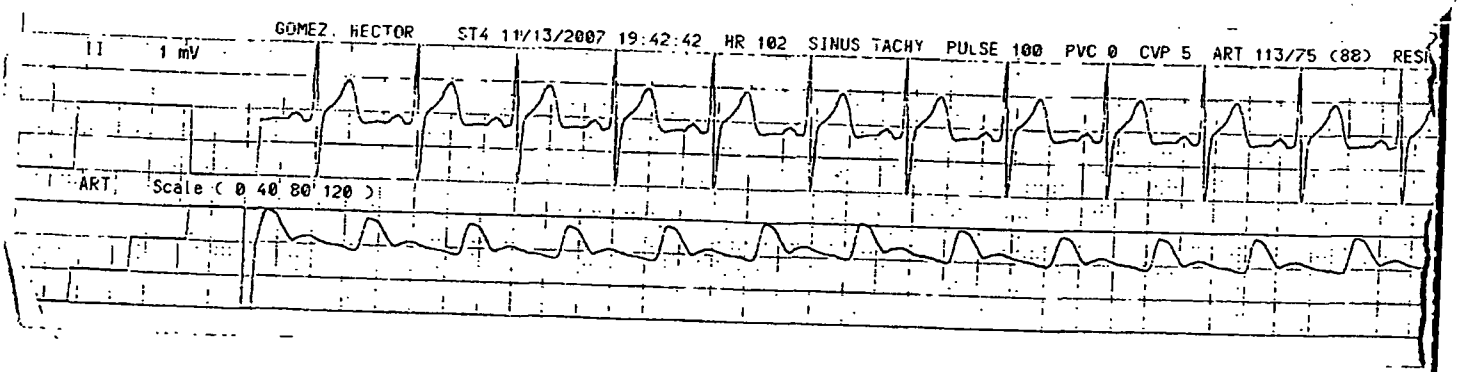
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page 5 of 12

THIS SPACE MONITOR STRIPS





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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007

page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM _____

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location A	✓ / location P	Suction A	Suction P	Drainage A	Drainage P
NGT						
OGT	✓	✓	LL		GR	
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/beg						
Nasal		+ Air		LI		CL BR

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

☐ Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other Blood clots

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
☐ Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm A	R Arm P	L Arm A	L Arm P	R Leg A	R Leg P	L Leg A	L Leg P
Limited ROM								
Weakness	X	X	X	XX	X	X	X	
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices — **Site / Type**
✓ A ☐ P SCD/foot pump (L) LE
☐ A ☐ P TED
☐ A ☐ P Traction
✓ A ☐ P Cast/splint (R) LE
☐ A ☐ P External fixator
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ✓ A ☐ P Unable to verbalize
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin Impairments — Location
☐ A ☐ P Surgical incision _____
dressing type/appearance _____
☐ A ☐ P Drain _____
☐ A ☐ P Drain _____
✓ A ☐ P Wound Sutures Top of Head
dressing type/appearance _____
☐ A ☐ P Other _____
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

✓ Any problems identified implement **Skin/Wound** section of the **POC.**

UP# 411230 rev 8/03

5 16 Fr placed 11-13-07 @ Air Bags

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007

page 6 of 12

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location (R) A-line
☒ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☒ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☒ Bloody ☐ Odor
Surrounding skin
☒ Normal ☐ Erythema ☐ Induration
☐ Other
Dressing change 0745 Time
Dressing type Clear

Surgical Incision #2 Location
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other
Dressing change Time
Dressing type

Wound #1 Location
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length ____ cm
Width ____ cm
Depth ____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined ____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other
Dressing change Time
Dressing type

Wound #2 Location
Type ☐ Surgical wound ☐ Leg ulcer ☐ Skin tear ☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length ____ cm
Width ____ cm
Depth ____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined ____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other
Dressing change Time
Dressing type

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	00	02	04	06
Suction/cough / Secretions	ST TN,T	C TN,T	C +	C TN,T	ST TN,T	ST Th,T,B	Sx S.B	Ø		Sx Th TN		
HOB>30 degrees unless contraindicated	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A line site ✓	✓	✓	✓	✓	—	✓	✓	✓	✓	✓	✓	✓
IV site ✓	✓	✓	✓	✓	—	✓	✓	✓	✓	✓	✓	✓
Chest tube patent ✓	—	—	—	—	—	—	NA	—	—	—	—	—
NG/OG place ✓	(F) Air Bolus	Dcd	--	(F) Air Bolus	→	→	AIV	✓	✓	✓	✓	✓
Mouth care	✓	✓	✓	✓	✓	✓	✓	—	✓	—	✓	—
Turn / Passive ROM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Side Rails	4X2	4X2	4X2	4X2	4X2	4X2	4X2	✓	✓	✓	✓	✓
Incen. Spir./ deep breathe	Vent	CDB Inc	→	→	Vent	→	Vent	→	→	→	→	→
Alarms on / Assessment reviewed	✓ MW	✓ MW	✓ MW	✓ MW	✓ MW	✓ MW	✓ ST	✓	✓	✓	✓	✓

UP# 411230 rev 8/03

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007

page 7 of 12

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☐ A ☑ P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	1	1	1	1
P	1	1	1	1

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☒ A ☑ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☒ A ☑ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

☞ Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☒ A ☑ P Arrhythmia ST

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	Trace				
P	tr				

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P					

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

☞ Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☒ A ☑ P: Suction functioning

☒ A ☑ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	M	R	R	R
P	CTA	CTA	D	CTA	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	7.0		22 cm
P	ET	8.0		25cm

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☞ Any problems identified, implement **Respiratory** section of the POC.

Intubated @ 1550 & 8.0 ET 24@Teeth Extubated @ 0845 and Placed on SLNC

* CONSULT *

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

PHYSICIAN CONSULTATION REPORT
Page 1 of 1

Written order in medical record ☐ Yes ☒ No Physician/Service notified by: ~~ARES~~ Resp Resp Date: 11/13/7
Requested by: Dr. M. Marshall Pager: _____ Service being consulted: ARES
Attending Name
CC/Reason for Request: intubation for Resp fx.
HPI: 27 yo s/p combative accident in STICC established today now c Resp fx. s/p extubation attempt failed
Allergies: _____
Medications: See Chart
PMH: _____
FH: _____ SH: _____
ROS: _____ ☐ All Others Negative
Exam: Unresponsive pt c SV c 100% FM tachy tachypnea 1° team neg cranial reflexes C-collar in place
Assessment/Plan: 60 mg propofol, IV DC + T MLS grade I C-collar maintained good c ETCO2, VSS: care to 1° team sternal @ 24 cm

Consult reviewed with and patient examined by Dr: TORRES. See Page 1 Addendum for attending note.

Resident's Signature	15340 Pager ID	11/13/7 Date of consult	1600 Time
Attending Physician Signature	14500 Pager ID	11/13/07 Date of consult	16:00 Time

Present during all critical portion of case JT

OTE 801015 Rev. 4/04

"PRGRECRD"

MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 6 mg NOT: 6.0 mg
Write a decimal point with a leading zero:
USE: 0.8mg Not: .8 mg

Date	Time	
11/13/07	06[illegible]	SICU Pt seemed not follow commands for written yesterday. He is Mex amerbe and would reptibly follow a few commands in spanish. Afebrile & acute events 38.4 37 107 22 125/79 95% RA 449 | 4555 Neuro: WAD, intubated, agrees expert, will localize, groans to pain, tries to follow commands Heart: RR/RR in plane. MMM, PERRL. Lungs confirmed Neck Miami I in plane Insulin - 10 Un Lungs: CTAB to Morgan 1/8 CV: Tachy, regular S1M/S2R. Abd: soft, wt/nd, hypoactive bs. Extrem: RLE: dressing C/D/I. UE: SCD in plane Maxect all time best. Labs 7.46 | 36 | 71 | 25.3 11.9 (11/33) 297 | 198 | 112 | 18/80 4 | 28 | 0.7 A/P: 26 y/o hom S/P open skull fracture. 1. Resp - Pt has been on minimal settings of CPAP over the past 24 hrs. He has few secretions. He is more awake than yesterday and tries to follow commands. ABG shows hypoxia but sats have been OK all day. We will plan to extubate later today. 2. Extrem - RLE ghurst necrotic tips of toes 2-4, once fully declared will manage surgically.

prgrecrd1

OTE 700222 Rev. 9/06

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962
Patient Name
MRN

STAMP PLATE AREA

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

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Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
1/3/08	0645	STICU. 3. Neuro - Pt remains partially unaware / confused. He follows commands both days yesterday - overall, neurologically he has improved since d/c of sedation/pain meds. 4. GI - once we extubate will decide on begin liquid diet if we feel he can protect his airway - Will have swallowing trials. If he cannot will disp NG and begin TF / IVF. 5. Renal - ↓ ISCures. 6. ID - Day 10 mero for enterobacter pneumonia. WBC NL, afebrile.

prgrecrd1

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[redacted] *PRGRECRD*

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INTERDISCIPLINARY PROGRESS NOTES

[redacted] P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

ATTENDING PHYSICIAN NOTE

[redacted] P:490943644 DOB:01/01/1951 L M
GOMEZ
MRN: HECTOR
Adm:11/01/07 M:2581962
NAME:

Date: 11/13 Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to

Upon personally questioning the patient, I can confirm that the following are the key history factors:

DM 42 y/o CC: closed head injury, resp failure s/p closed head injury

Physical Examination: Pulse: 118 BP: 85/62 Resp Rate: 20 T: 38.4 (37.3) Input: 4490 Output: 4555

Neuro: agitated, intermittent RR
Eyes: PERRL
ENT: ETT - taped
CV: tachy
Resp: Coarse (B)
GI/Nutr: BS+, soft NT/ND
CU/Renal:
MuscSkel: MAE x4
Skin:
Psych: moderately appropriate
Other:

7.46 36 71
PS 10+5
12 / 33 / 387
Lovenox
Continue
9.6 80 24
Insulin gtt
40 / 112 / 18 / 0.7 / 4.1
460 / 262

☐ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☑ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☑ I have personally discussed the case with

meropenem D7/8

Diagnoses/Problems

1. DM, Insulin - extubated to FM mask O2 ☐New ☐Improved ☐Unchanged ☐Worsening
2. ☐New ☐Improved ☐Unchanged ☐Worsening
3. intubation - d/c PS doesn't improve ☐New ☐Improved ☐Unchanged ☐Worsening
4. ☐New ☐Improved ☐Unchanged ☐Worsening
5. ☐New ☐Improved ☐Unchanged ☐Worsening
6. pneumonia - continue meropenem D7/8 ☐New ☐Improved ☐Unchanged ☐Worsening

Management Options/Recommendations

1.
2. hyperglycemia - continue insulin drip until glucose controlled to
3. improve
4.
5. OOB to chair
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☑High
☐ Pt is critically ill/injured. I spent 35 minutes providing critical care to this patient.
Overall Condition: ☑Critical ☐Serious ☐Fair ☐Good

Marshall Signature Date

UMA #19100-13 revised 11/06

PRGRECRD

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INTERDISCIPLINARY PROGRESS NOTES

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Adm:11/01/07 M:2581962
Patient Name
MRN

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/13/07	3:15 pm	Nutrition F/u – Pt has been on TF via OGT providing ~100% nutritional needs. Pt extubated today, OGT d/c'd. Insulin gtt D/C'd - Transition to NPH. Labs 11/13: 148 / 4 / 112 / 28 / 18 / 0.7 / 80 / 9.4 / 3.4 / 5.1 — 11/12 Prealbumin 28.1 Meds - Noted plan – ① Monitor labs, wt, I/Os ② Diet advancement - if unable to tolerate, place DHT + resume TF ③ F/u + activ SA recs pm Amy J Blum RD/LD/CNSD 1-2733

prgrecrd1

OTE 700222 Rev. 9/06

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Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5087173

MRN: 002581962
Date Exam Completed: 11/14/2007 03:45
Last Update: 11/14/2007

EXAMINATION: PORTABLE CHEST 11/14/07 03:45:00

ACCESSION NUMBER: 5087173

INDICATION: SKULL FRACTURE, HYPOXIA, FAILED EXTUBATION

COMPARISON: 11/13/07

FINDINGS: Single frontal radiograph of the chest with right costophrenic sulcus collimated from field of view demonstrates endotracheal tube with tip overlying the trachea at the level of the clavicular heads. Left central venous cathter with tip overlying the superior vena cava. Enteric tube with tip distal to diaphragm, overlying the stomach. Stable size and contour of the cardiomediastinal silhouette. Lungs demonstrate left basilar subsegmental atelectasis with small effusion. Visualized portions of the bony thorax are unchanged.

IMPRESSION:

1. Left basilar subsegmental atelectasis with small effusion.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW
I have reviewed the images and agree with the findings in this report.

History: /p blow to head with skull fracture

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:39 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5087173

MRN: 002581962
Date Exam Completed: 11/14/2007 03:45
Last Update: 11/14/2007

Technologist: LORI RAGER
Interpreter 1: PHILIP COSTELLO
Interpreter 2: MARQUES BRADSHAW
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: PHILIP COSTELLO
Date Authenticated: 11/14/2007

Transcribed by: Tech IntTalk

* N R S R E C R D *

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date ~~NOV 14 2007~~

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # _____

APP = Assume Pain Present

1 2 3 4 5 6 7 8 9MM

TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / POWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP Hi / LOW	DAILY WEIGHT / TIME / LOSS:GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR R	MOTOR L	VERBAL / EYES
08	99	95	1/16		123/75	98	8				97		cc rounds	0/3	4	B	4	B	5	5	ET/2
09		99	2/16		124/83	94	10				97		0930: Protonix started 0945 Diluadid 1mg								
10		103	16		120/77	92	8				96										
11	99	105	16		124/79	92	8				96										
12	37	110	16		139/84	97	10				95		cc rounds	0/3	4	B	4	B	5	5	ET/2
13		111	16		144/86	99	9				97										
14	37	115	3/16		121/A	90	7				96		500 ml NS Bolus Sputum Sent								
15		108	11		124/68	86	8				95										
16	37	111	11		111/62	82	9				93										
17		106	11		119/66	80	8				95			0/3	5	B	5	B	5	5	ET/2
18	37	105	11		117/69	84	10				97		Bladder Scan								
19		110	14/11		114/68	84	10				96										
20	37	0	14/11		111/64	79	9				96										
21		113	11/11		128/47	88	18				95			0/3	5	B	5	B	5	5	T/4
22		107	11/11		114/76	81	11				100										
23		108	—/9		114/64	81	6				100		ABG								
24	98	89	14/9		114/63	81	7				100		Bath, Lm O, Nm B								
01		92	14/9		112/61	80	7				99		irrigate foley	0/4	5	B	5	B	5	5	T/4
02		98	2/9		114/61	81	7				100		CBC cm IQ (x2) S, ABG RCXR								
03		98	2/9		113/63	82	12				99										
04	98	82	—/9		123/68	87	11				100			0/4	5	B	5	R	5	5	T/4
05		82	5/9		122/68	88	12				100										
06		82	—/9		127/70	91	12				100										
07		82	5/9		131/73	92	14				100		ABG								

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
[signature]	[initials]		
[signature] 7-1930/7-1930	SH		

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	D5 1/2 NS c 20 meq KCl/L	+ Unit/ml	Insulin	Protonix 10mg/ml	IV Meds	NS Boluses	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	100 / 100	0.9 / 1	19.2 / 19								120	120
09	100 / 200	1.6 / 3	19.2 / 35								121	241
10	100 / 300	3.4 / 5	19.2 / 57					Promote		10 / 10	131	372
11	100 / 400	2.8 / 8	19.2 / 76							20 / 30	142	514
12	100 / 500	2.4 / 10	19.2 / 95							20 / 50	141	655
13	100 / 600	3.1 / 13	19 / 114							40 / 90	162	817
14	100 / 700	3.8 / 17	19 / 133							40 / 130	162	979
15	100 / 800	3.2 / 20	19 / 142	50 / 50	500 / 500				30 / 30	40 / 170	742	1721
16	100 / 900	3.4 / 23	19 / 161							40 / 210	162	1883
17	100 / 1000	4.9 / 28	19 / 180							40 / 250	164	2047
18	100 / 1100	3.6 / 32	19 / 199		500 / 1000					40 / 290	163	2210
19	100 / 1200	5.9 / 38	19 / 218							60 / 350	185	2395
20	100 / 1300	5.4 / 43	19 / 237							60 / 410	184	2579
21	100 / 1400	6.1 / 49	19 / 256						36 / 36	60 / 470	184	2763
22	100 / 1500	7.6 / 56	19 / 275		500 / 1000					60 / 530	185	2948
23	100 / 1600	5.9 / 62	19 / 294		500 / 1000 / 500					60 / 590	1682	4630
24	100 / 1700	4.7 / 67	24 / 318							60 / 650	189	4819
01	100 / 1800	4.3 / 71	24 / 342							70 / 720	198	5017
02	100 / 1900	6.4 / 77	24 / 366							70 / 790	200	5217
03	100 / 2000	6.5 / 84	24 / 390						60 / 90	70 / 860	201	5418
04	100 / 2100	8.5 / 90	24 / 414							70 / 930	203	5621
05	100 / 2200	8.9 / 99	24 / 438							70 / 1000	203	5824
06	100 / 2300	8.9 / 108	24 / 462							70 / 1070	203	6027
07	100 / 2400	6.1 / 114	24 / 486							70 / 1140	200	6227

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 4 2007

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0715 Report Received from Night Nurse, Chart reviewed MW 0730 Physical Assessment Performed and documented Per Flowsheet. See Flowsheet for Vitals, I+O and Vent D's. MW 0930 Promote TF started via OG Tube, Placement Confirmed via Air Bolus. MW 1200 CC Rounds. Orders Received 1500 CC Team Made Aware of PT VOP. MW 1400 CC Team Made Aware of VOP. 500ml NS Bolus Started. MW 1415 Sputum culture Sent. PT Placed on Bivent, Settings Per Flowsheet MW 1700 CC Team Made Aware of VOP, 500ml NS Bolus started, Bladder scanned 0ml Noted In Bladder 1930 Assessed patient. Recieved report. Assumed care. SP 2000 Bath. Linen. Main I & O. Assessment WNL. SP 2300 Report to oncare RN. Chart Check completed. SP

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 4 2007

page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	Foley	STOOL	EMES	NG	RESID			
08	150	150	150/150							
09	300	150	100/250			50	50			
10	360	60	60/310							
11	405	45	45/355							
12	455	50	50/405							
13	480	25	25/430							
14	500	20	20/450							CC Team Aware of OOP
15	550	50	50/500							CC Team Aware of OOP
16	590	40	40/540							
17	595	5	5/545							
18	600	5	5/550							CC Team Aware of OOP
19	600	0	0/550							CC Team Aware of OOP
20	600	0	0/550							CC Team Aware of OOP
21	600	0	0/550							
22	600	0	0/550							
23	900	300	300/850							
24	975	75	75/925							
01	1025	50	50/975				0 R			
02	1075	50	50/1025							
03	1125	50	50/1075							
04	1175	50	50/1125							
05	1225	50	50/1175							
06	1275	50	50/1225							
07	1350	75	75/1300				0 R			

UP# 411230 rev 8/03

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

page 10 of 12

SAFETY

- ☑ Hospital ID band on ☐ Allergy band on
- ☐ Call system accessible
- ☑ Bed in low position ☑ Bed brakes on ☑ Bed alarms on
- ☑ Bed heel pressure relief ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact

- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status ☐ Violent behavior
  - ☐ History of falls ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances ☐ Other _____
- ○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose redated	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:	0	3	0	3
TOTAL POINTS:	6	☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

☑ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					
TRACH CARE					
BATH					
FOLEY / PERI CARE					
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE					
SKIN CARE					
PEG SITE CARE					
TYPE OF DIET					
% EATEN					
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

page 4 of 12

Triglycerides - 188
PT - 16.5
PTT - 32.9
INR - 1.28

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES			HEMATOLOGY					CHEMISTRY								
TYPE O, DEL	MODE RATE	FiO2 TV	PEEP PS	CPAP PIP	MIN VENT		A/V PH	PO2 PCO2	HCO3 O2 SAT	HCT HGB	WBC RBC	PT PTT	PLT INR	NA K	CL CO2	GLUC BUN	CREAT CA	MG PHOS		FSBS		
1015 Vent	PAV 16	SC 425	12				A 7.46	78 40	27 95											113 .02		08
						1050	A 7.45	84 41	27.7 96.5											121 .05		09
																				116 .04		10
																				105 .03		11
Vent	40	40	16																	111 .05		12
1415 Vent	11	50		.6	5	1130	A 7.41	36 95	22.6 94.9											114 .06		13
1545						1129	A 7.44	78 40	26.9 94.6											106 .07		14
																				109 .07		15
																				121 .07		16
							A 7.44	78 40	26.5 94.5											105 .06		17
																				126 .06		18
✓	BiPAP 11	.50			.6	5														114 .09		19
	9	50		.26	13	5.5														119 0.1		20
							A 7.44	70 37	25.4 96.5											—		21
																				102 0.12		22
																				91 0.1		23
																				107 0.1		24
								586												105		01
							A 7.41	36	25.8 97	28 9.4	6.8 3.2	14.6 34.1	31.7 1.28	139 3.5	115 25	101 26	0.7 58.6	24 2.9		118 0.11		02
✓	BiPAP 9	50		24	.8	6.0 24														114 0.12		03
																				125 0.13		04
																				107 0.19		05
							A 7.46	46 37	25.4 97.1											107 0.19		06
																				94 0.18		07

PTOF 1560

UP# 411230 rev 8/03

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/13/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(R) FEM	D/I	0730	(L) DP (L) UE
P	S	FEM	D/I	1920	RAC FW4

High Dose Heparin catheter Type: _____ Date Inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: QLC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	(L) SC LSC	S	D/I	(+)
P		S	D/I	(+)

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

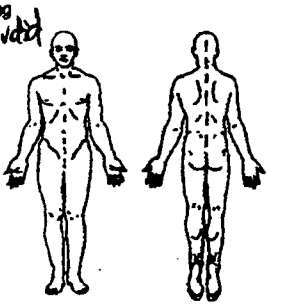
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☑P Receiving analgesic therapy Plan D/C'd/d/c

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



○ Any problems identified, implement Comfort section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☑ Psychosocial / Spiritual / Education	M	M
☑ Comfort	M	M
☐ Neurologic / LOC	M	M
☑ Safety	M	M
☑ Functional / Musculoskeletal	M	M
☑ Skin / Wound	M	M
☑ Cardiovascular	M	M
☐ Respiratory	M	M
☑ Gastrointestinal	M	M
☑ Genitourinary	M	M
☑ Nutrition	M	M
☐ Discharge Planning		
☐ Other		

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE _____ TIME 0730

PM SHIFT ASSESSMENT
SIGNATURE _____ TIME 1920

UP# 411230 rev 8/03

NRSRECRD

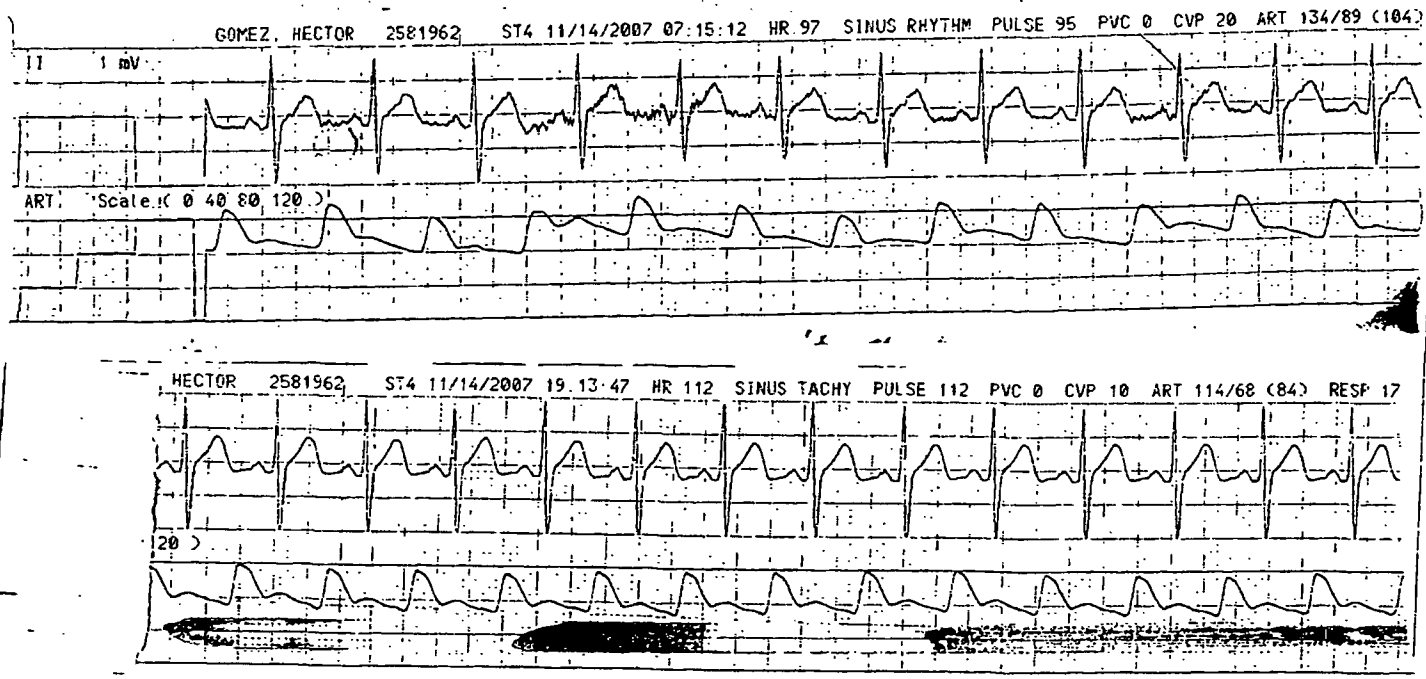
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page 5 of 12

THIS SPACE MONITOR STRIPS



UP# 411230 rev 8/03

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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM _____

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm) _____
☐ A ☐ P Hernia, site _____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location A	✓ / location P	Suction A	Suction P	Drainage A	Drainage P
NGT						
OGT	[illegible]		LI	LI	BR	BR
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

Any problems identified, implement **Gastrointestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other _____

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)
Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____ # weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm A	R Arm P	L Arm A	L Arm P	R Leg A	R Leg P	L Leg A	L Leg P
Limited ROM								
Weakness	X	X	X	X	X	X	X	X
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location _____

Devices Site / Type
☐ A ☐ P SCD/foot pump (R) LE
☐ A ☐ P TED
☐ A ☐ P Traction Pins (R) Toes
☐ A ☐ P Cast/splint
☐ A ☐ P External fixator
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ☐ A ☐ P Unable to verbalize (ETT)
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing
Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale ☐ A ☐ P Cyanotic ☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose ☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool ☐ A ☐ P Diaphoretic

Skin Impairments Location
☐ A ☐ P Surgical incision _____
dressing type/appearance _____
☐ A ☐ P Drain _____
☐ A ☐ P Drain _____
☐ A ☐ P Wound Sutures Top of Head
dressing type/appearance _____
☐ A ☐ P Other _____
☐ A ☐ P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

Any problems identified implement **Skin/Wound** section of the **POC.**

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
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Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

page 6 of 12

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location Top of Head
☒ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☒ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☒ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change OTA Time
Dressing type OTA

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	00	02	04	06
Suction/cough / Secretions	SY Th,T	SY ThT	SY ThT	SY —	Bivent	Bivent	Bivent	SY mTh	SY ThTh			
HOB>30 degrees unless contraindicated	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
A line site ✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
IV site ✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Chest tube patent ✓	NA →						NA					
NG/OG place ✓	NA →						rAw	✓	✓	✓	✓	✓
Mouth care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Turn / Passive ROM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
Side Rails	1X2	1X3	1X2	1X2	1X2	1X3	X3	✓	✓	✓	✓	✓
Incen. Spir./ deep breathe	Vent →						Vent					
Alarms on / Assessment reviewed	MW	MW	MW	MW	MW	MW	SH	SH	SH	SH	SH	SH

PT Turned q 10

UP# 411230 rev 8/03

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☒ A ☐ P Chemical paralysis/sedation Propofol

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A				
P				

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☒ A ☐ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☒ A ☐ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☒ A ☐ P Arrhythmia SR-ST

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	Trace				→
P	Trace				

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P					

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate A	Rate V	mA A	mA V	Sensitivity A	Sensitivity V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☒ A ☐ P: Suction functioning

☐ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	D	L	D
P	R	R	D	L	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	8.0		25cm
P	↓	8.0		25cm

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal A	Suction amt or H_2O Seal P	Drainage A	Drainage P	Air Leak A	Air Leak P	SQ emphysema A	SQ emphysema P

Any problems identified, implement **Respiratory** section of the POC.

UP# 411230 rev 8/03

"PRGRECRD"

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/08

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	STICU

11/14/07 0630 Pt failed extubation overnight. He was unable to handle his secretions and had a poor A/a gradient. Yesterday he was returned @ 4pm. He is consented for a tracheostomy + PEG. Tube feeds were held overnight. While awake yesterday he pulled on his foley and was had bloody urine since then. clot.

105 98 86 16 125/71 CVP 9 100%
1173 | 2725 → 1775 UOP + 1100 UO

Gen: NAD, intubated/sedated, localizes to pain
HEENT: PERRL - MMM, ETT in place. area of swelling over decreased, no lacerations or crepitus.
Neck: Midline / no masses
CV: RRR s M/r/g.
Lungs: CTAB, NVBS.
Abd: Soft, nt/nd hyperactive bs.
Extrem: RLE toes unchanged. SCDs @ LE.

Labs:

7.44/36/77/27 on PRVC · R16/PEEP 12/500/80%
142/108/29 (+13) 9.1
3.6/25/0.8 2.7 (3.8) 8.9/34 16.4/359

A/P: 27 y/o hm s/p MVC accident.
1. Neuro: sedated on propofol. Pt was off of sedation yesterday and was still unresponsive to commands.
2. Pulm: Pt still has very poor A/a gradient. Plan to switch to BiVent trial and ABG 1hr following switch. Secretions are MINIMAL per report but can bronch if they increase. Plan to trach and peg ASAP to prevent long ventilation.

prgrecrd1

OTE 700222 Rev. 9/06

PRGRECRD

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

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USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	STICU
11/14/07	07[illegible]	3. CV - RR on sedation & vaso pressors - & current issues. 4. GI - Plan to restart TF today, Promote @ 20 and advance as tolerated. Pt has BM now. Once PEG in place will plan on feeding through that. 5. Renal/GU - Blood through foley likely due to urethral trauma. Has decreased overnight + 5 clots. If it does not clear in the next 8hrs or so will consider urine culture. 6. FEN - TF Promote @ 20 @ 6°. With propofol still going will plan to check triglyceride level this am. 7. ID - Day 8/8 of meropenem. Afebrile, WBC & & B.C & evidence of infection.

prgrecrd1

OTE 700222 Rev. 9/06

[redacted] MUSC

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
MRN: ____ Adm:1.1/01/07 M:2581962 ____
NAME: _____

ATTENDING PHYSICIAN NOTE

Date: 1/14 Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to _____

Upon personally questioning the patient, I can confirm that the following are the key history factors:

Dyspnea & CC resp failure. s/p [redacted] fall on chest

Physical Examination: Pulse: 84 BP: 125/71 Resp Rate: 95% T: 100.5 98 Input: 1173 Output: 2725

Neuro: Intubated, sedated
Eyes: PERRLA
ENT: MMM, pink
CV: RRR
Resp: CTA B
GI/Nutr: BS+ soft NT/ND
CU/Renal:
MuscSkel: PIV, sensation of hrs
Skin: scalp lac CDE
Psych:
Other:

745 14 88 27
5 PIV 16 500 + 0 = 500 1000 NS + 20 KCl
1 x 45 100
9.1 nebulizer
142 | 108 | 27 1.3 2.7
36 X 0.8 38 propofol 30
4 X 355 100 Lasix 40

☐ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☐ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☐ I have personally discussed the case with _____

meropenem D8/8

Dr Lien

Diagnoses/Problems

1. Resp failure - vent, trach tomorrow ☐New ☐Improved ☐ Unchanged ☐Worsening
2. [redacted] ☐New ☐Improved ☐ Unchanged ☐Worsening
3. hypoalbuminemia - start nutren shp ☐New ☐Improved ☐ Unchanged ☐Worsening
4. ☐New ☐Improved ☐ Unchanged ☐Worsening
5. Acute metabolic encephalopathy - distract TF, agitation ☐New ☐Improved ☐ Unchanged ☐Worsening
6. ☐New ☐Improved ☐ Unchanged ☐Worsening

Management Options/Recommendations of goal

1.
2. pneumonia - stop meropenem, send sputum for culture
3.
4.
5. Trach + PEG tomorrow.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☐High
☐ Pt is critically ill/injured. I spent 35 minutes providing critical care to this patient.
Overall Condition: ☐Critical ☐Serious ☐Fair ☐Good

CMuehlbauer
_____ Signature Date _____

UMA #19100-13 revised 11/06

prgrecrd1

OTE 700222 Rev. 9/06

"PRGRECRD"

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
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USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/14/07	1500	TOT meeting: Pt. on vent; remains on TBII - stable as per RN notes. Care discussed c nurse manager Hubbard & staff nurse - O'Bannon RN
11/14/07	1530 Rm	ORTHO - Staff Remains intubated + sedated. Has failed extubation x 3. Toe remains ischemic (R) foot c necrosis distal to PIP joint of 2nd → 4th Toe. Plantar club is healthy and perfused up to MTP level, dorsal is still poorly perfused upto D-P from distal aspect of metatarsals 2-4. Hallux is healthy. No evidence yet of infxn. Recommend to await tissue to declare as dorsal foot then consider distal transmetatarsal amputation of 2-4 covered c plantar tissue flap. JLH

prgrecrd1

OTE 700222 Rev. 9/06

MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date of Surgery: 11/15/2007
Surgeon: Stuart M. Leon, MD
Assistant(s): James P. Stokes, MD

PREOPERATIVE DIAGNOSIS: Closed-head injury with epidural hematoma.

POSTOPERATIVE DIAGNOSIS: Closed-head injury with epidural hematoma.

TITLE OF PROCEDURE: Placement of percutaneous endoscopic gastrostomy tube.

ANESTHESIA: Local MAC.

OPERATIVE INDICATIONS: Mr. Gomez is a 56-year-old Hispanic gentleman who was struck by a crane while at a construction site earlier this month. The patient sustained several injuries, the most significant of which was a closed-head injury with an epidural hematoma. This injury has left Mr. Gomez neurologically devastated. We have discussed with the family the need to place a percutaneous endoscopic gastrostomy tube for continued enteral feeds and nutritional support. The risks and benefits of this procedure were discussed with the patient's family in great detail, and operative consent was obtained for us to proceed at this time.

OPERATION TECHNIQUE: Mr. Gomez was laid supine in bed in the surgical trauma intensive care unit. The patient was given Dilaudid and was then placed on a propofol drip in order to achieve conscious sedation. After these medications has been given, a bite block was placed between the patient's teeth, and an Olympus endoscope was then passed per oral down the esophagus and into the stomach without difficulty. The stomach was insufflated with air. A site was chosen along the left subcostal margin for placement of our gastrostomy tube. This site was noted to be approximately 2 fingerbreadths distal to the left subcostal margin and had an excellent finger counterpulsation when viewed from within the stomach endoscopically. This site was also noted to easily transilluminate. The patient's abdomen was then prepped and draped in the usual sterile fashion. One percent lidocaine was injected at the gastrostomy tube entry site. After appropriate local anesthetic had been administered, a 1-cm stab incision was made at this location, and a Jelco needle was then passed through the center of the stab incision directly into the stomach on the first attempt. The Jelco needle was grasped with the endoscopic snare. A guidewire was then threaded through the needle and in turn grasped with the endoscopic snare. The endoscope snare and guidewire were then withdrawn retrograde out of the stomach and esophagus and brought out through the oral cavity. A 24-French Ponsky gastrostomy tube was then attached to the free end of the guidewire, and the guidewire and gastrostomy tube were then pulled antegrade back through the esophagus and into the stomach. The endoscope followed. The gastrostomy tube button was noted to seat nicely along the anterior wall of the stomach. It was approximately 2 cm from the skin surface. The bolster was placed so that the gastrostomy tube button remained snug to the anterior wall of the stomach but was able to freely rotate with digital manipulation. The remaining gastrostomy appliance was replaced. The stomach was then deinsufflated of air, and the endoscope was removed. Mr. Gomez tolerated this procedure well without incident. Throughout the entire procedure his heart rate, blood pressure, and pulse oximetry were continuously monitored, and at

no point during the procedure did he be[illegible]ne hypoxic, bradycardic, or hypotensive.

ATTESTATION STATEMENT: I, Stuart Leon, MD, was personally present, assisted, and supervised all aspects of this procedure from beginning to end.

Dictated by: Stuart M. Leon, MD

Stuart M. Leon, MD
Surgeon

249384 / 38351 /
JOB: 370330
DD: 11/15/07 04:10 PM
DT: 11/17/07 11:10 AM

Additional CC:_____

DOCID: 18232249384

Electronically signed by STUART LEON, MD on 11-19-2007 at 07:52:45 PM

MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date of Surgery: 11/15/2007
Surgeon: Christian Minshall, MD
Assistant(s): James P. Stokes, MD

PREOPERATIVE DIAGNOSIS: Closed head injury with epidural hematoma.

POSTOPERATIVE DIAGNOSIS: Closed head injury with epidural hematoma.

PROCEDURES: Tracheostomy.

ANESTHESIA: Moderate sedation.

INDICATIONS FOR PROCEDURE: Mr. Gomez is a 26-year-old Hispanic gentleman who was struck by a crane while at a construction site earlier this month. He sustained a severe head injury at that time and, despite multiple attempts, has been unable to tolerate extubation and protect his airway. It was felt he was a good candidate for a tracheostomy. The risks, benefits, and alternatives were explained and informed consent was obtained.

DESCRIPTION OF PROCEDURE: The patient was prepped and draped in normal sterile fashion after having his C-collar removed and placed between sandbags. A vertical incision, approximately 2 cm, was made approximately 1 fingerbreadth above the sternal notch. This was carried down through the subcutaneous tissue and to the platysma. The strap muscles were then split and dissected down sharply with cautery until the trachea was visualized. Anterior tracheal fascia was then dissected off the trachea using the Blue Rhino percutaneous kit. Percutaneous tracheostomy was then performed between the second and third tracheal rings. This was done with serial dilation and an 8-cuffed Shiley trach was placed and was visualized in the airway. End-tidal CO2 was returned and end-tidal volumes were maintained. The skin incision was closed with an interrupted 2-0 Vicryl, and the trach was secured in place with interrupted 2-0 nylon stitches.

Dr. Minshall was present and scrubbed throughout the entire case.

Dictated by: James P. Stokes, MD

Christian Minshall, MD
Surgeon

435784 / 35634 /
JOB: 372205
DD: 11/27/07 04:27 PM
DT: 11/29/07 08:12 AM

Additional CC:

DOCID: 18232435784

Edited By JAMES STOKES on 11-30-2007 at 06:13:58 PM
Electronically signed by TODD MINSHALL, MD on 12-05-2007 at 03:50:23 PM

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5087924

MRN: 002581962
Date Exam Completed: 11/15/2007 03:05
Last Update: 11/15/2007

Chest

Accession Number: 5087924

Indication: 27 yo hm sp crane accident

Comparison: 11 14 07

Findings: Single frontal radiograph of the chest demonstrates unchanged position endotracheal tube tip well above carina , left central venous catheter tip over superior vena cava , nasogastric tube over stomach and temperature probe unchanged since prior exam . The size and contour of the cardiomediastinal silhouette and hilum are unchanged . Lungs again demonstrate air space disease in the left base and no pneumothorax, or pleural effusion . Fractured right clavicle is unchanged

Impression:
No significant interval change.

History: 27 yo hm sp crane accident

Technologist: ELMON WATSON
Interpreter 1: STEPHEN SCHABEL
Interpreter 2:
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: STEPHEN SCHABEL
Date Authenticated: 11/15/2007

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: **01/07/2008 10:39 AM**
Printed by: LINCOLN, COURTNEY

NRSRECRD

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response

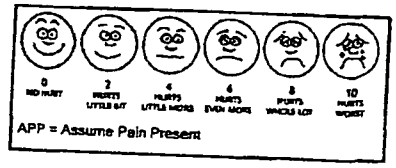
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #



APP = Assume Pain Present



TIME	TEMP	PULSE	SPON VENT RESP	CUFF BP	A-LINE BP	MAP PCWP	CVP	PA	CO CI	SVR	S.O.	ICP HI LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R L	PUPILS REACTION R L	MOTOR R	MOTOR L	VERBAL EYES
08	37.2	83	15/9		123/70	89	13				100			0/3	5	B	5	B	4 ET 3
09	37.3	81	8/9		137/71	89	11				100								
10	37.4	83	2/9		132/74	92	11				99								
11	37.3	90	-/9		115/64	80	5				98								
12	37.3	88	-/9		118/65	83	4				99								
13	37.3	85	1/9		120/65	83	5				98			0/3	6	B	6	B	4 ET 2
14	37.0	84	-/9		149/90	110	18				96								
15	37.0	76	-/9		149/88	107	19				97								
16	36.9	80	-/9		137/80	98	15				96								
17	37.1	78	-/9		145/85	104	17				97			0/3	3	B	3	B	4 ET 2
18	37.3	89	1/9		153/87	112	17				95								
19	37.2	93	3/9		160/88	108	15				100								
20	37	86	-/9		132/70	81	12				100								
21	37.1	73	2/9		151/83	102	14				100			0/3	4	B	4	B	5 T 4
22	37.5	84	-/8		155/88	111	16				99								
23	37.3	73	-/8		154/87	112	15				100		Bath, Lines Δ						
24	37.4	82	-/8		126/69	84	11				100		↑ Propofol to 55						
01	37	79	-/8		116/62	80	10				99		D1 bolus 1g Prop 65	4/3	4	D	4	B	4 T 1
02	37.2	89	3/8		144/78	104	14				100		↑ Propofol to 70	0					
03	37.2	79	1/8		134/70	82	13				100								
04	36.5	71	-/8		127/71	91	12				99								
05	37	76	-/8		137/71	96	14				100			0/3	4	B	4	B	4 T 1
06	37	77	-/8		138/70	98	14				100								
07	37	84	-/8		135/77		15				100		Fola, Irrigated.						

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 2007

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
Suzanne Hartman RN 19-730	SH		
Robyn Handley RN 7A-7P	RH		

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NRSRECRD

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IV SOLUTIONS / ADDITIVES

| TIME | D5 1/2 NS + 20 meq/L KCl | Propofol (1000mg/100mL) | Insulin (250 units/250mL) | | |

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PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0700 Received report and assumed care of pt RS 0745 Assessment completed. Propofol off held for neuro assessment. Pt open eyes to voice, PERRL, but will not follow commands c extremities, withdraws only. Miami J collar secure. Lungs c rhonchi throughout, clears c suctioning. Vent settings (BIVENT) on flowsheet. Abd soft/nontender c @BS. Receiving TF through OGT, placement checked @ intake. Foley c amber urine RS 1000 Turned, repositioned, open eyes to voice, does not follow Commands c extremities, but does have spontaneous mvt x4 extrem. 2+ pedal pulses, mvt @ foot RS 1230 Dr. Brown notified Ø U/o x 2 hrs. Orders to flush Foley, wait 30 min, if Ø output, then replace Foley RS 1245 Foley flushed c NS, yellow urine c small blood clots aspirated, then good U/o (>200cc) RS 1305 TF held and OGT placed to suction by Dr. Stokes for GT placement this afternoon RS 1330 PEG placement procedure started - Dr. Stokes and Dr. Lam c endoscopy nurses. Time out done. Pt given 2mg IV Versed prior to procedure. Remain on propofol. 1345 PEG placed LUQ c difficulty. PEG tube placed to gravity drain. Pt remained sedated throughout procedure RS 1545 Continues to have adequate U/o. GT c small amt drainage (TF). Per Dr. Brown, TF will be held until tomorrow RS 1700 Bed bath / linen change done RS 1800 BS: 69, 15 mL D50 given IVP per protocol. Will recheck BS in 15 min. RS 1815 BS: 114, infusion re-initiated RS

1930 Received report and completed chart check c off going RN. Assessed patient VS drips and assured care SH

2200 Complete bath + linens. SH

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 2007

page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloocy
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

TIME	OUTPUT CUM	OUTPUT HOURLY	URINE (100)	GASTRIC STOOL	GASTRIC EMESIS	GASTRIC OG/NG	GASTRIC RESID (100)	CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
08	50	50	50/50				10 R			
09	125	75	75/125							
10	140	15	15/140							
11	140	0	0/140							
12	140	0	0/140				0 R			
13	390	250	250/390							
14	465	275	75/465			200	200			
15	495	30	30/495							
16	555	100	60/555				40			
17	605	50	50/605				40			
18	635	30	30/635							
19	685	60	60/685							
20	735	50	50/735							
21	785	50	50/785							
22	840	55	55/840				140			
23	1300	460	460/900				200 140 60			
24	1350	50	50/950							
01	1400	50	50/1000				0/200			
02	1450	50	50/1050							
03	1500	50	50/1100							
04	1550	50	50/1150							
05	1580	30	30/1180							
06	1680	100	50/1230				50/200			
07	1730	50	50/1280							

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 2007

SAFETY

- ☑ Hospital ID band on
- ☐ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position
- ☑ Bed brakes on
- ☐ Bed alarms on
- ☑ Bed heel pressure relief
- ☑ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☑ Patient at high risk for infection
  - ☐ Immunocompromised ☑ Other central lines, Foley, surgical wounds, vent
- ☑ Patient assessed for placing self or others at risk that may require restraint usage
  - ☑ Cognitive impairment/altered mental status (prn fol)
  - ☐ History of falls
  - ☐ Withdrawal from addictive substances
  - ☐ Violent behavior
  - ☑ Previous use of restraints
  - ☐ Other _____
- ☑ Any risk criteria identified, implement the **Safety** section of the **POC**.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose Sedated	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:		3		3
TOTAL POINTS:	6	☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

If score ≥ 6, implement **Safety** section of the **POC**.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					
TRACH CARE					
BATH					
FOLEY / PERI CARE					
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE					
SKIN CARE					
PEG SITE CARE					
TYPE OF DIET					
% EATEN					
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

Trig=2cc

	VENTILATION							BLOOD GASES				HEMATOLOGY					CHEMISTRY									
	TYPE O, DE	MODE / RATE	FiO_2 / TV	PEEP / PS	CPAP / PIP	MIN VENT	P / T	A/V / PH	PO_2 / PCO_2	HCO_3 / O SAT	HCT / HGB	WBC / RBC	PT / PTT	PLT / INR	NA / K	CL / CO	GLUC / BUN	CREAT / CA	MG / PHOS	(N)	FSBS	
	V	BV 8	40				34 / 12																08
																					106 .18		08
																					105 .18		09
																					111 .19		10
																					111 .2		11
																					127 .21		12
																					98 .2		13
																					93 .19		14
																					93 .18		15
																					95 .17		16
																					95 .16		17
	V	BV 8	40	0	E2	22 / 6															60 .100		18
																					69		19
																					114 .22		20
																					108 .03		21
																					76 0.02		22
																					110 .02		23
																					93 0.04		24
								A 7.43	100 37	251 48	28 9.1	7.3 3.2	16.2 345	329 1.35	144 3.9	113 25	98 19	0.7	2.2 3.5	1.37			01
																					99 0.04		02
																					94 0.05		03
																					97 0.005		04
																					96 0.005		05
																					108 0.005		06
																					114 0.05		07

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page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/13/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	Rfem	D,I	0730	⊕BR ⊕WF
P	S	Rfem	D+I	2100	+BR+WF

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: QLC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	CSC	S	D,I	⊕
P	CSC	S	D+I	⊕

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

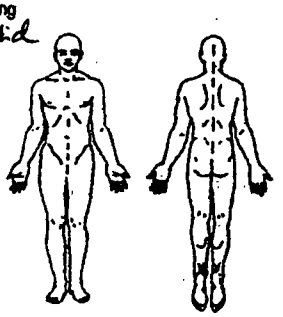
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☑P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☑P Receiving analgesic therapy prn dilaudid

(A) Pain Score: 0 Patient Goal: 0-2
(P) Pain Score: 0 Patient Goal: 0-2

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



○ Any problems identified, implement Comfort section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☑ Psychosocial / Spiritual / Education	M	M
☐ Comfort	M	M
☑ Neurologic / EENT	M	M
☑ Safety	M	M
☑ Functional / Musculoskeletal	M	M
☐ Skin / Wound	M	M
☑ Cardiovascular	M	M
☑ Respiratory	M	M
☑ Gastrointestinal	M	M
☑ Genitourinary	M	M
☐ Nutrition	M	M
☐ Discharge Planning		
☐ Other		

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE Robyn Flanders R TIME 0745

PM SHIFT ASSESSMENT
SIGNATURE Suzanne Hatton TIME 1450

UPN 411230 rev 8/03

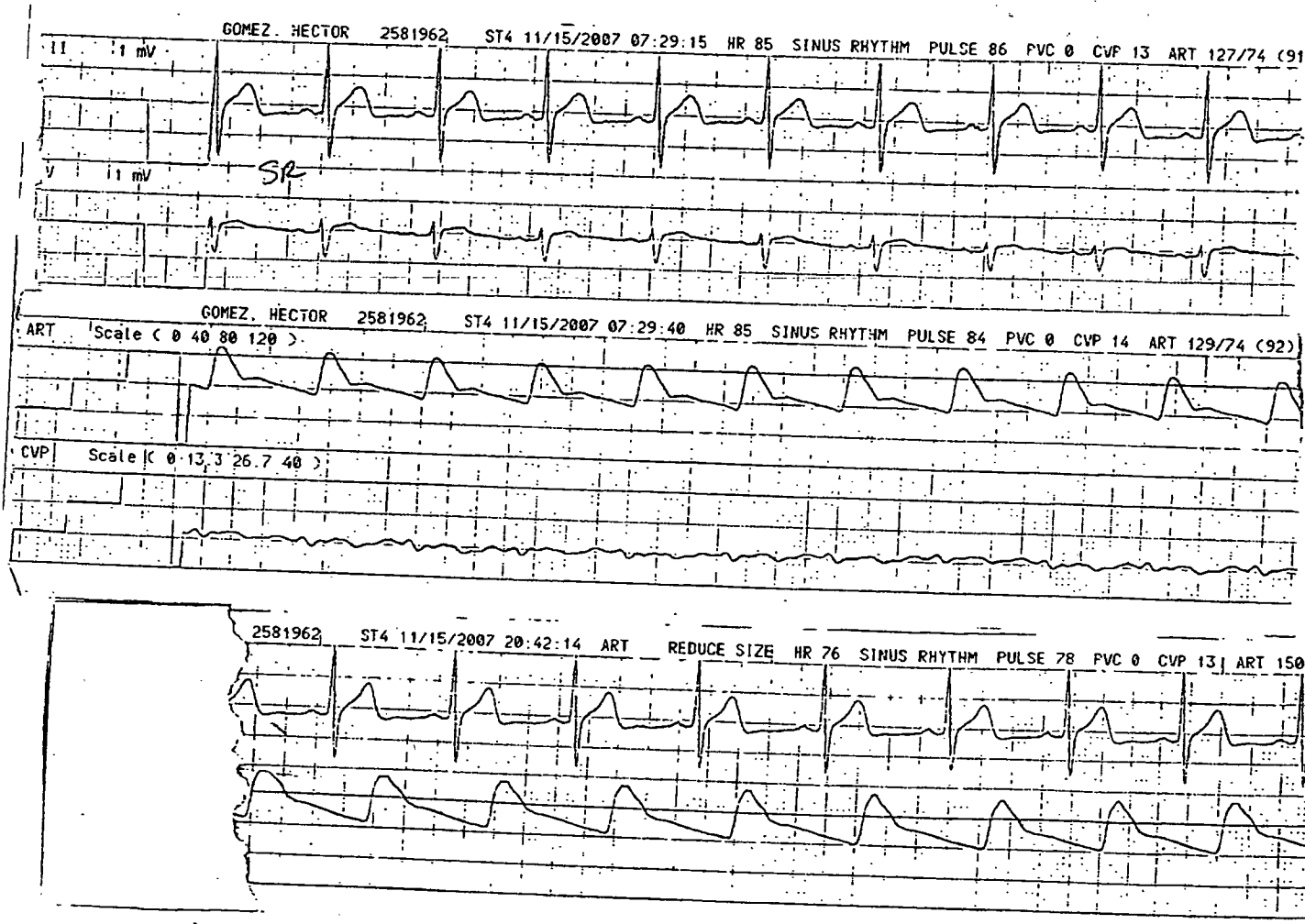
* N R S R E C R D *

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page 5 of 12



UP# 411230 rev 8/03

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page 8 of 12

GASTROINTESTINAL

☐A ☐P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM 11/15/07

Abnormal Findings

Bowel sounds present
☐A ☐P Hyperactive
☐A ☐P Hypoactive
☐A ☐P Absent

Abdomen
☐A ☐P Firm ☐A ☐P Guarded
☐A ☐P Distended ☐A ☐P Tender
☐A ☐P Nausea ☐A ☐P Vomiting
☐A ☐P Girth (cm) _____
☐A ☐P Hernia, site _____

Bowel habits
☐A ☐P Incontinent
☐A ☐P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐A ☐P Poor dentition ☐A ☐P Stomatitis
☐A ☐P Lesions ☐A ☐P Thrush

GI tubes/drains ✓=placement

Type	✓ / location A	✓ / location P	Suction A	Suction P	Drainage A	Drainage P
NGT						
OGT	@air	+ Air	F	F	F	F
Small bore feeding tube						
G-tube						
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

✓ Any problems identified, implement **Gastrointestinal** section of the POC.

GENITOURINARY

☐A ☐P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐A ☐P Menses

Abnormal Findings

Voiding patterns
☐A ☐P Incontinent ☐A ☐P Dysuria
☐A ☐P Bladder distention ☐A ☐P Unable to void
☐A ☐P Frequency/Urgency

Urine characteristics
☐A ☐P Oliguria ☐A ☐P Polyuria
☐A ☐P Anuria ☐A ☐P Cloudy
☒A ☐P Amber ☐A ☐P Hematuria
☐A ☐P Foul odor
☐A ☐P Other _____

Tubes / devices
☐A ☐P Condom ☒A ☐P Foley
☐A ☐P Suprapubic
☐A ☐P Nephrostomy ☐R ☐L
☐A ☐P Ureterostomy ☐R ☐L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A _____ P _____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐A ☐P Problematic penile or vaginal bleeding or discharge
☐A ☐P Concerns about sexual function
☐A ☐P Gravid (if yes, complete **Uterine/Fetal** section)
✓ Any problems identified, implement **Genitourinary** section of the POC.

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐A ☐P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐A ☐P SVD
☐A ☐P C/Section
☐A ☐P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐A ☐P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm A	R Arm P	L Arm A	L Arm P	R Leg A	R Leg P	L Leg A	L Leg P
Limited ROM								
Weakness	✓	✓	✓	✓	✓	✓	✓	✓
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐A ☐P Tingling
☐A ☐P Numbness Location _____

Devices Site / Type
☒A ☐P SCD/foot pump bilat
☐A ☐P TED
☒A ☒P Traction pins @ 1,2,3,5 toes, 1 pin kidney L foot
☐A ☐P Cast/splint _____
☐A ☐P External fixator _____
☐A ☐P Other _____

Speech
☐A ☐P Slurred ☒A ☐P Unable to verbalize
☐A ☐P Aphasic ☐A ☐P Difficulty swallowing
✓ Any problems identified, implement **Functional / Musculoskeletal** section of the POC.

SKIN / WOUND

☐A ☐P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐A ☐P Pale ☐A ☐P Cyanotic ☐A ☐P Jaundice
Turgor ☐A ☐P Loose ☐A ☐P Tight
Temperature ☐A ☐P Cool ☐A ☐P Diaphoretic

Skin Impairments

Location
☒A ☐P Surgical incision sutures R lateral foot
dressing type/appearance _____
☐A ☐P Drain _____
☐A ☐P Drain _____
☒A ☐P Wound sutures - scalp OTA
dressing type/appearance _____
☒A ☐P Other skin staple @ toes 2,3,4,5
☐A ☐P Other _____

Wound vac™

	Location	mmHg	Suction
A			
P			

✓ Any problems identified implement **Skin/Wound** section of the POC.

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 2007

page 6 of 12

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	Sx Th.T	Sx Th.T	Sx Th.T	Sx Th.T	Sx Th.T	Sx Th.T	Sx THT	Sx Sm THT		Sx THT		
HOB>30 degrees unless contraindicated	RT	RT	RT	RT	RT	RT	✓	✓	✓	✓	✓	✓
A line site ✓	RT	RT	RT	RT	RT	RT	✓	✓	✓	✓	✓	✓
IV site ✓	RT RT	RT RT	RT RT	RT RT	RT RT	RT RT	✓	✓	✓	✓	✓	✓
Chest tube patent ✓	/	/	/	/	/	/	N/A					
NG/OG place ✓	RT	RT	RT	RT	RT (PEG)	RT	✓ PEG	✓	✓	✓	✓	✓
Mouth care	RT	RT	RT	RT	RT	RT	✓	✓	✓	✓	✓	✓
Turn / Passive ROM	RT	RT	RT	RT	RT	RT	✓	✓	✓	✓	✓	✓
Side Rails	x2	x2	x2	x2	x2	x2	x3	✓	✓	✓	✓	✓
Incen. Spir./ deep breathe	vent	vent	vent	vent	vent	vent	Vent					
Alarms on / Assessment reviewed	RT RT	RT RT	RT RT	RT RT	RT RT	RT RT	✓ SH	✓	✓	✓	✓	✓

UP# 411230 rev 8/03

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 2007

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☒ A ☐ P Chemical paralysis/sedation Propofol

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	1	1	1	1
P	1	1	1	1

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:						
	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☒ A ☐ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☐ A ☐ P Unable to assess

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

☑ Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart SR

☐ A ☐ P Arrhythmia _____

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	Tr	Tr	Tr	Tr	
P	Tr	Tr	Tr	Tr	

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	1+	2+	1+	1+	
P	1	1	1	1	

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

☑ Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☑ A ☐ P: Suction functioning

☑ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	R	R	R
P	R	R	R	R	R

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ET	8.0	/	25cm
P	ET	8.0	—	25

☐ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☑ Any problems identified, implement **Respiratory** section of the POC.

"PRGRECRD"

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/15		Ortho S: intubated / sedated O: (R) toes 2-4 dorsal ischemia to mid MT. plantar surface perfused Hallux perfused + signs of infection (1) cont to let ischemia declare (2) plan for medialized amputation ± plantar flap 15228

prgrecrd1

OTE 700222 Rev. 9/06

PRGRECRD

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Patient Name
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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

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Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	STICU

11/15/06 0600

Pt had low UOP overnight. Foley flushed, bolused ~ NS, UOP back up to around 50cc/hr. He was recently weaned to FiO_2 of 30%.

98° 82 127/70 CVP 12 100% /

5467 / 1275

Gen: Intubated · Sedated & FC.

HEENT: Head swelling is decreased, has remained on same dressing. ETT/OG in place. Sclera low c/o pt. PERRL 3→2

Neck: Miami J.

Lungs: CTAB, NVBS. Breathing over vent.

CV: RRR & M/G/R.

Abd: soft, NT & BS.

GU: Foley in place & draining

Extr: SCDs in place BLE. FLE unchanged from previous exam.

Labs / / / 0 6.8 / 9.4 / 28 / 317

144 | 115 | 26 | 109 | 8.6
3.5 | 25 | 0.7 | 2.4 | 2.9

INR 1.29.
Triglycerides: 135

Precedex Continuous Dilaudid PRN

Bilat Pf 24
TH 6.0
TPEEP 10

A/P: 27 y/o man s/p BFT to hand & open skull fx.

1. Neuro: Sedated on propofol & FC. Pupils unchanged from previous exam. Will wean propofol & work to wake up.
2. Resp: F_iO_2 weaned to 40% & PEEP now. Will try to wean if possible, then work to [illegible] if PW. Trach bed
3. CV: RRR: HD currently stable.
4. GI/FEN: on TF @ goal & residuals PERs today. Triglycerides N/.
5. ID: Afebrile, WBC ↓ to 6.8. & evidence of infection.

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PRGRECRD

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INTERDISCIPLINARY PROGRESS NOTES

2581962
Gomez, Hector

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	STICU
11/15/07	0725	Renal - MAP down overnight. Bolused & appropriate rose. Plan to increase IVF to 125 cc/hr. change to NS. Prophylaxis: On heparin + SCDs.
11/16/07	7am	ortho Sedated, intubated. RLE: 2-4 digits becoming more black & necrotic, but overall demarcation not changed. Pt moving R&L LE spontaneously but cannot otherwise assess motor sensory fxn A/P: crush injury to Rt 2-4 toes - - will likely need TMA @ some point, possibly early next week. will d/w Dr. Wolf

prgrecrd1

OTE 700222 Rev. 9/06

MUSC
MEDICAL UNIVERSITY
OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5089460

MRN: 002581962
Date Exam Completed: 11/16/2007 03:55
Last Update: 11/16/2007

EXAMINATION: PORTABLE CHEST 11/16/07 03:55:00

ACCESSION NUMBER: 5089460

INDICATION: OPEN SKULL FRACTURE, INTUBATED

COMPARISON: 11/15/07

FINDINGS: Single frontal radiograph of the chest demonstrates interval pullback of temperature probe and removal of enteric tube. Endotracheal tube and left central venous cather in unchanged position. normal size and contour of the cardiomediastinal silhouette. Increase in density, left lower lobe. Visualized portions of the bony thorax demonstrate right clavicle fracture.

IMPRESSION:

1. Left lower lobe atelectasis possibly with superimposed pneumonia.

VOICE DICTATED BY: Dr. MARQUES BRADSHAW
I have reviewed the images and agree with the findings in this report.

History: 27 yo hm sp bft to head with open skull fracture

Technologist: LORI RAGER

Proxy Signer:

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:39 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5089460

MRN: 002581962
Date Exam Completed: 11/16/2007 03:55
Last Update: 11/16/2007

Interpreter 1: JAMES RAVENEL
Interpreter 2: MARQUES BRADSHAW
Interpreter 3:
Date Dictated:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/16/2007

Transcribed by: Tech IntTalk

NRSRECRD

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(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

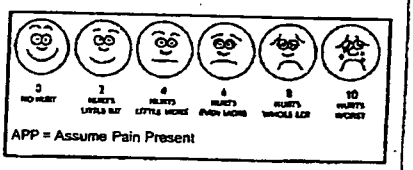
VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #



APP = Assume Pain Present



TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S.O.	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN / SEDATION	PUPILS SIZE R	PUPILS REACTION R	PUPILS REACTION L	MOTOR R	MOTOR L	VERBAL / EYES
08	37.3	82	9/8		136/77	99	13				100			0/3	5	B	5	B	4	4 / ET 4
09	37.3	89	10/8		139/77	99	14				100									
10	37.1	83	9/8		150/83	103	18				100									
11	37.1	77	-/8		159/87	109	16				99									
12	37.3	86	-/8		136/77	98	14				100									
13	37.4	83	-/8		137/76	94	14				99			0/3	4	B	4	B	4	4 / ET 2
14	37.4	88	-/8		138/79	98	16				100									
15	37.4	91	7/8		133/75	94	12				100									
16	37.5	95	1/8		152/77	95	14				98									
17	37.5	97	1/8		124/71	90	11				98			0/3	5	B	5	B	4	4 / ET 2
18	37.5	82	5/8		168/92	115	15				100									
19		110	19/8		146/90	94	22				95									
20	37.5	107	0/8		126/71	91	11				98									
21		97	4/8		198/87	104	9				100		2130 pt grimacing Too Stimulation	0/2	5	B	5	B	5 / 6	T 4
22		97	0/8		137/78	109	8				98			0						
23		93	98/8		130/73	93	8				98									
24	37.2	87	98/8		134/78	98	8				100									
01		99	0/8		149/84	105	9				99			0/2	5	B	5	B	6 / 6	T 4
02		96	0/8		131/77	94					98									
03		100	1/8		140/80	99					99									
04	37.4	108	2/8		135/79	98					98			0/2	5	B	5	B	5 / 5	T 4
05		83	0/8		143/83	104					99									
06		86	1/8		155/92	118					100									
07		107	88/8		147/86	107					100									

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 2007

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
[illegible] 7P-7A	[illegible]		
Robyn Flanders RN 7A-7P	RF		

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IV SOLUTIONS / ADDITIVES

TIME	D5 1/2 NS + 20 mEq KCl/L	insulin (250 units/250 mL)	propofol (1000 mg/100 mL)	A-line 1/hr	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	100 100	0.2 0.2	35.8 35.8	6					135	135
09	50 150	0.2 0.4	35.8 71.6	6 12					135	270 220
10	50 200	0.2 0.6	35.8 107.4	6 18					135	405 305
11	50 250	0.2 0.8	35.8 143.2	6 24					135	540 390
12	50 300	1.1 1.9	35.8 179	6 30					86	476
13	50 350	0.9 2.8	35.8 214.8	6 36					86	562
14	50 400	0.9 3.7	35.8 250.6	6 42					86	648
15	50 450	0.8 4.5	35.8 286.4	6 48					86	734
16	50 500	0.8 5.3	35.8 322.2	6 54					86	820
17	50 550	0.8 6.1	37.6 359.8	6 60					90	910
18	50 600	0.8 6.9	37.6 397.4	6 66					90	1000
19	50 650	0.8 7.7	37.6 435	6 72					90	1090
20	50	0.8	37.6	6					90	1180
21	50 100	0.9 9.5	37.6 472.2	6 84					90	1270
22	50	0.4 9.9	37.6 508.4	6 90			30		90	1360
23	50	0.4	37.6	6 96			30		90	1450
24	50	0.2	26 512	6 102			30		90	1540
01	50 150	0.2 10.5	26 538	6 108			30		90	1630
02	50	0.2	26	6			30		90	1720
03	50 100	0.2 10.9	26 570	6 114			30		90	1810
04	50	1.2	26	6			30		90	1900
05	50 150	1.2	26	6 132			30		90	1990
06	50	8	26	6 138			30		90	2080
07	50 100	4 14.5	26 1694	6 144			30 250		90	2170

UP# 41[illegible] Rev 8/03

2470

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(STAMP PLATE)

NOV 16 2007

24 HOUR CRITICAL CARE PATIENT RECORD Date _____
page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

(0700) Received report and assumed care of pt @ (0745) Assessment completed as noted on flowsheet. Eyes open spontaneously - pt tracks c eyes, but does not follow commands c extremities, withdraws only. PERRL. ETT secure, on BIVENT, lungs c mild rhonchi, secretions thin. Abd soft c (+)BS. Dtrs do PEG site D.I. GT clamped / Pt NPO for tracheostomy procedure later today. Foley draining amber urine c small blood clots. (R) foot c 2+ pedal pulse and (+) mvt. Toes 2,3,4,5 c black nailbeds and tips, pinkish at Rt (0915) A-line ? CVP tubing changed. A-line site care done. (R) fem. Rt (1130) Resting calmly c propofol gtt, eyes open to pain, tracks, withdraws to pain Rt (1315) Dr. Marshall and CC team here to round. Plans to trach pt this afternoon. Pt has been NPO. 12pm Lovenox held Rt (1600) Turned / repositioned. Awaiting tracheostomy. Eyes open spontaneously, spontaneous mvt all 4 extremities to (1730) Dr. Stokes and Dr. Marshall ready for tracheostomy, bronchs ready, Consent in chart, Cheryl (RT) present Rt (1810) 8.0 shiley placed by Dr. Stokes, (+)CO2 detector + procedure, placed back on BIVENT, continue c settings as of 0800. Pt tolerated procedure well c fentanyl ? removed by _____ (1915) Rt / report rec'd. Chart / MAR reviewed. (2000) Assessment completed. Pt. does not follow commands, does not consistently track c eyes. (R) hand appears to localize to track side, all other extremities w/d to pain, but legs do move spontaneously as well. (2130) Pt. sleeping to no apparent stimulus. See MAR. (2300) Pt. no longer sleeping VS stable. (0000) Pt. is (+)2 from propofol, follows commands, nodded head yes/no somewhat approp.

UP# 411230 rev 8/03

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page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS									BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY	[illegible]	STOOL	EMESIS	OG/NG	RESID											
08	35	35	35/35															
09	65	30	30/65															
10	69	4	4/69															
11	139	70	70/139															
12	199	60	60/199															
13	269	70	70/269															
14	314	45	45/314															
15	364	50	50/364															
16	504	140	140/504															
17	534	30	30/534															
18	594	60	60/594															
19	654	60	60/654															
20	1054	400	400/1054															
21	1179	125	125/1179															
22	1329	150	150															
23	1529	200	200															
24	1679	150	150															
01	1779	100	100															
02		100	100															
03	1979	100	100															
04	2129	150	150															
05	2229	100	100															
06	2329	100	100															
07	2429	100																

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 2007

page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☐ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position
- ☑ Bed brakes on
- ☑ Bed alarms on
- ☑ Bed heel pressure relief
- ☑ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☑ Patient at high risk for infection
  - ☐ Immunocompromised
  - ☑ Other Central lines, Foley, vent, bedrest, surgical wound
- ☑ Patient assessed for placing self or others at risk that may require restraint usage
  - ☑ Cognitive impairment/altered mental status (Sedation)
  - ☐ Violent behavior
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other _____
- ☑ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose Sedation	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/dx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below
SUBTOTAL:		3		3
TOTAL POINTS:	6	☐ N/A Patient < 6 years old		

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

If score ≥ 6, implement Safety section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE	0615 AD				
TRACH CARE				0400	
BATH				0500	
FOLEY / PERI CARE				0500	
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE				0500	
SKIN CARE	2000			0500	
PEG SITE CARE				0500	
TYPE OF DIET	NPO				
% EATEN					
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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* N R S R E C R D *

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HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 2007

(STAMP PLATE)

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES			HEMATOLOGY				CHEMISTRY								
TYPE O, DEL	MODE / RATE	FiO_2 / TV	PEEP / PS	CPAP / PIP	MIN VENT	P High / T High	AV / PH	PO_2 / PCO_2	HCO_3 / O_2SAT	HCT / HGB	WBC / RBC	PT / PTT	PLT / INR	NA / K	CL / CO_2	GLUC / BUN	CREAT / CA	MG / PHOS	FSBS	
VENT	SIMV 8	40				20 / 7.0														
																			101 .005	08
																			107 .005	09
																			108 .005	10
																			114 .02	11
																			107 .02	12
																			104 .02	13
																			102 .01	14
																			107 .02	15
																			107 .02	16
																			107 .02	17
																				18
																			104 .02	19
																				20
																			98 .01	21
																			99 .01	22
																			99 .01	23
																			100 .01	24
																			104 .01	01
										7.9 / 8.9	6.7 / 3.1		3.4	135 / 3.6	107 / 23	110 / 17	0.6 / 8.2	1.1 / 9.2	99 .05	02
																			119 .02	03
																			118 .01	04
																			102 .02	05
																			98 .02	06
																				07

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page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/13/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(R) Rad	I	0730	(R) BR (L) WF
P	S	(R) Fem	I	2000	(R) BR/WF

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: QVC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	(L) SC	S	D, I	(+)
P	(L) SC	S	I	(+)

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

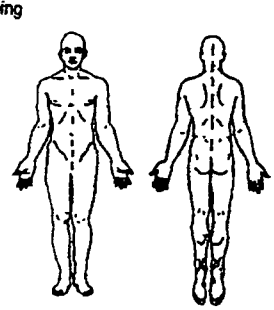
Abnormal Findings

☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☑P Receiving analgesic therapy PM

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling



Location of pain (on the diagram, put an X on the area where the patient complains of pain)

○ Any problems identified, implement **Comfort** section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☑ Psychosocial / Spiritual / Education	M	M
☑ Comfort	M	M
☐ Neurologic / EENT	M	M
☐ Safety	M	M
☑ Functional / Musculoskeletal	M	M
☐ Skin / Wound	M	M
☑ Cardiovascular	M	M
☐ Respiratory	M	M
☐ Gastrointestinal	M	M
☐ Genitourinary	M	M
☐ Nutrition	M	M
☐ Discharge Planning		
☐ Other		

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE Robyn Landry RN TIME 0740

PM SHIFT ASSESSMENT
SIGNATURE [illegible] RN TIME 2000

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NRSRECRD

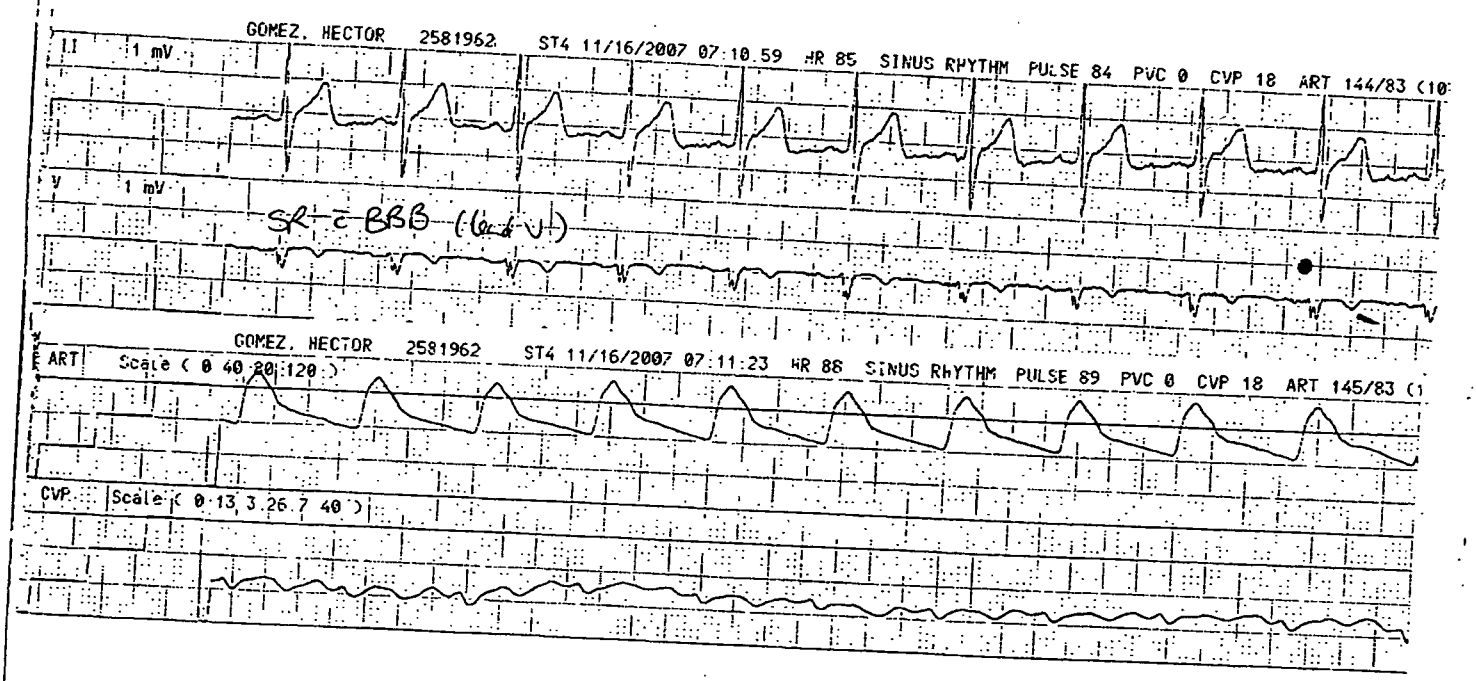
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page 5 of 12



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page 8 of 12

GASTROINTESTINAL

☐A ☐P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM 11-15

Abnormal Findings

Bowel sounds present
☐A ☐P Hyperactive
☐A ☐P Hypoactive
☐A ☐P Absent

Abdomen
☐A ☐P Firm ☐A ☐P Guarded
☐A ☐P Distended ☐A ☐P Tender
☐A ☐P Nausea ☐A ☐P Vomiting
☐A ☐P Girth (cm)
☐A ☐P Hernia, site

Bowel habits
☐A ☐P Incontinent
☐A ☐P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐A ☐P Poor dentition ☐A ☐P Stomatitis
☐A ☐P Lesions ☐A ☐P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT						
Small bore feeding tube						
G-tube	✓	✓	C	F	C	F
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

Any problems identified, implement **Gastrointestinal** section of the POC.

GENITOURINARY

☐A ☐P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐A ☐P Menses

Abnormal Findings

Voiding patterns
☐A ☐P Incontinent ☐A ☐P Dysuria
☐A ☐P Bladder distention ☐A ☐P Unable to void
☐A ☐P Frequency/Urgency

Urine characteristics
☐A ☐P Oliguria ☐A ☐P Polyuria
☐A ☐P Anuria ☐A ☐P Cloudy
☒A ☐P Amber ☒A ☐P Hematuria (Small Clots)
☐A ☐P Foul odor
☐A ☐P Other

Tubes / devices
☐A ☐P Condom ☒A ☐P Foley
☐A ☐P Suprapubic
☐A ☐P Nephrostomy ☐R ☐L
☐A ☐P Ureterostomy ☐R ☐L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A P

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐A ☐P Problematic penile or vaginal bleeding or discharge
☐A ☐P Concerns about sexual function
☐A ☐P Gravid (if yes, complete **Uterine/Fetal** section)
Any problems identified, implement **Genitourinary** section of the POC.

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum # weeks gestation
☐A ☐P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
Document any variations from normal limits in progress notes.

Postpartum Delivery date
☐A ☐P SVD
☐A ☐P C/Section
☐A ☐P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐A ☐P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness	✓	✓	✓	✓	✓	✓	✓	✓
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐A ☐P Tingling
☐A ☐P Numbness Location

Devices Site / Type
☒A ☐P SCD/foot pump blue foot
☐A ☐P TED
☒A ☐P Traction pins @ toes 1,2,3,5
☐A ☐P Cast/splint 1 pin @ R heel foot
☐A ☐P External fixator
☐A ☐P Other

Speech
☐A ☐P Slurred ☒A ☐P Unable to verbalize
☐A ☐P Aphasic ☐A ☐P Difficulty swallowing
Any problems identified, implement **Functional / Musculoskeletal** section of the POC.

SKIN / WOUND

☐A ☐P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐A ☐P Pale ☐A ☐P Cyanotic ☐A ☐P Jaundice
Turgor ☐A ☐P Loose ☐A ☐P Tight
Temperature ☐A ☐P Cool ☐A ☐P Diaphoretic

Skin impairments

Location
☒A ☐P Surgical incision sutures @ lateral foot
dressing type/appearance
☐A ☐P Drain
☐A ☐P Drain
☒A ☐P Wound sutures to scalp OTA
dressing type/appearance
☒A ☐P Other skin / redness blanch @ toes 2,3,4,5
☐A ☐P Other
Wound vac™

	Location	mmHg	Suction
A			
P			

Any problems identified implement **Skin/Wound** section of the POC.

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SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	00	02	04	06
Suction/cough / Secretions	SX TN	SX Th.T	SX Th.T	SX TN	SX Th.T	SX B	S B	S Sang	S Q	S Q	S W	S T
HOB>30 degrees unless contraindicated	RX	RX	RX	RX	RX	RX						
A line site ✓	RD	RD	RX	RX	RX	RX						
IV site ✓	RX	RX	RX	RX	RX	RX						
Chest tube patent ✓	/	/	/	/	/	/	NA	—	—	—	—	→
NG/OG place ✓ (PEG)	/	/	/	/	/	/	NA	—	—	—	—	→
Mouth care	RX	RX	RX	RX	RX	RX						
Turn / Passive ROM	RX	RX	RX	RX	RX	RX						
Side Rails	X2	X2	X2	X2	X2	X2	X2	X2	X2	X2	X2	X2
Incen. Spir./ deep breathe	vent	vent	vent	vent	vent	vent	✓	✓	✓	✓	✓	✓
Alarms on / Assessment reviewed	RX	RX	RX	RX	RX	RX						

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NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.

☑ A ☐ P Chemical paralysis/sedation propofol

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	1	1	1	1
P	1	1	1	1

Reflexes Absent

☐ A ☐ P Cough ☐ A ☐ P Gag

☐ A ☐ P Corneal

Drainage

☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea

☐ A ☐ P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☑ A ☐ P Cervical collar Miami J

☐ A ☐ P Cervical traction

☐ A ☐ P Halo

☐ A ☐ P Tongs

☐ A ☐ P Shunt: _____

☐ A ☐ P Codman reference # _____

☐ A ☐ P Other _____

Impairments

☐ A ☐ P Hearing

☐ A ☐ P Eyes

☑ A ☐ P Unable to assess ETT

Fontanel

☐ A ☐ P Full ☐ A ☐ P Bulging

☐ A ☐ P Sunken

Emotional status

☐ A ☐ P Inconsolable

☑ Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☑ A ☐ P Arrhythmia SR c BBB (lead V)

☐ A ☐ P Click

☐ A ☐ P S3

☐ A ☐ P Distant heart sounds

☐ A ☐ P S4

☐ A ☐ P Rub

☐ A ☐ P Capillary refill > 3 sec.

Murmur

☐ A ☐ P Faint

☐ A ☐ P Moderate

☐ A ☐ P Loud

☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A	warm		& dry		
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	Tr	Tr	Tr	Tr	
P					

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	1+	2+	1+	1+	
P	1+	1+	1+	1+	

Pacemaker / wires

☐ A ☐ P Permanent ☐ A ☐ P Transvenous

☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter

☐ A ☐ P AICD

☑ Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☑ A ☐ P: Suction functioning

☑ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations (Bivent)

☐ A ☐ P Labored ☐ A ☐ P Shallow

☐ A ☐ P Irregular ☐ A ☐ P Orthopnea

☐ A ☐ P Stridor ☐ A ☐ P Pleural rub

☐ A ☐ P Accessory muscle use

☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation

☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	R	R	R
P	R	R	D	R	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	ETT	8.0	—	23 cm
P	Shiley	8	WNL	

☑ A ☐ P Emergency trach supply box

☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

☑ Any problems identified, implement **Respiratory** section of the POC.

PRGRECRD

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not .5 mg

Date	Time	
		SICU
11/6/07	0645	acute events overnight. F_iO_2 weaned to 40%. Got peg yesterday. ~~Crew cath~~, foley irrigated x 1 overnight.
		37.4 37.0 89 132/77 CVP 15
		~~Goal~~ 3685 | 1730 → 1780 UOP + 200 OG + 250 PEG.
PS 14/5 @ 20 @100		Orient NAD, intubated/sedated (-) FC
Propofol 60		HEENT: Laceration c/d/I & S/E. ET in place. PERRL.
Insulin gtt		Neck: Miami J in place.
TF held on		CV: RRR & m/g/r
~~Levaquin~~		Lungs: CTAB, NWBS.
Ceftriaxone		Abd: soft, nd (+) bs, PEG in place
Haldol PRN		Extrem: RLE ecchymosed dressing c/d/I remains, toes 2-5. cool
		7.43/37/100/25.1 on ~~PRVC~~ Bivent PH 22 F_iO_2 40 PEEP 7 Tv 6.5 Rate 8
		14 / 113 / 19 (<98
		3.9 / 25 / 0.7
		7.37 / 78 / 9.1 (329 INR 1.25 Triglycerides 202
		A/P: 27 M/o hm s/p crane accident ~ open skull fx
		1. Neuro: Sedated on propofol + prn haldol. PERRL. (+) new spray. After trach today, will wean sedation after that.
		2. Resp: Will ↓ Ps to 20, cont to wean Bivent. Plan to trach today
		3. CV: (-) issues. Will ↓ fluids to 50 cc/hr.
		4. GI/SEEN - PEG yesterday, will start TF by PEG after trach. A
		5. Renal - cont to ~~irrigate~~ bladder as needed, urine clear.
		6. ID - WBC nl, Afebrile, (-) evidence of infxn Fawlatt

prgrecrd1

OTE 700222 Rev. 9/06

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Medical University of South Carolina
Charleston, SC
843-792-2123

Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5091251

MRN: 002581962
Date Exam Completed: 11/17/2007 06:12
Last Update: 11/18/2007

EXAMINATION: CHEST 11/17/07 06:12:00

ACCESSION NUMBER: 5091251

INDICATION: head injury, skull and facial fx, failed extubation multiple times, s/p trach 11/16

COMPARISON: 11/16/07

FINDINGS: Single frontal radiograph of the chest demonstrates interval removal of endotracheal tube and placement of a tracheostomy tube which overlies the tracheal air column. Nasogastric tube is been removed. Left subclavian central venous catheter is unchanged. The size and contour of the cardiomediastinal silhouette and hilum are unchanged in appearance as well. Lungs again demonstrate left pleural effusion with left basilar atelectasis. Right midshaft clavicular fracture.

IMPRESSION:

1. Exchange of endotracheal tube for tracheostomy tube.
2. Left pleural effusion with left basilar atelectasis.

VOICE DICTATED BY: Dr. KIRK KIZZIAH
I have reviewed the images and agree with the findings in this report.

History: head injury, skull and facial fx, failed extubation multiple times, s/p trach 11/16

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:38 AM
Printed by: LINCOLN, COURTNEY

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page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials

UP# 411230 rev 8/03

NRSRECRD

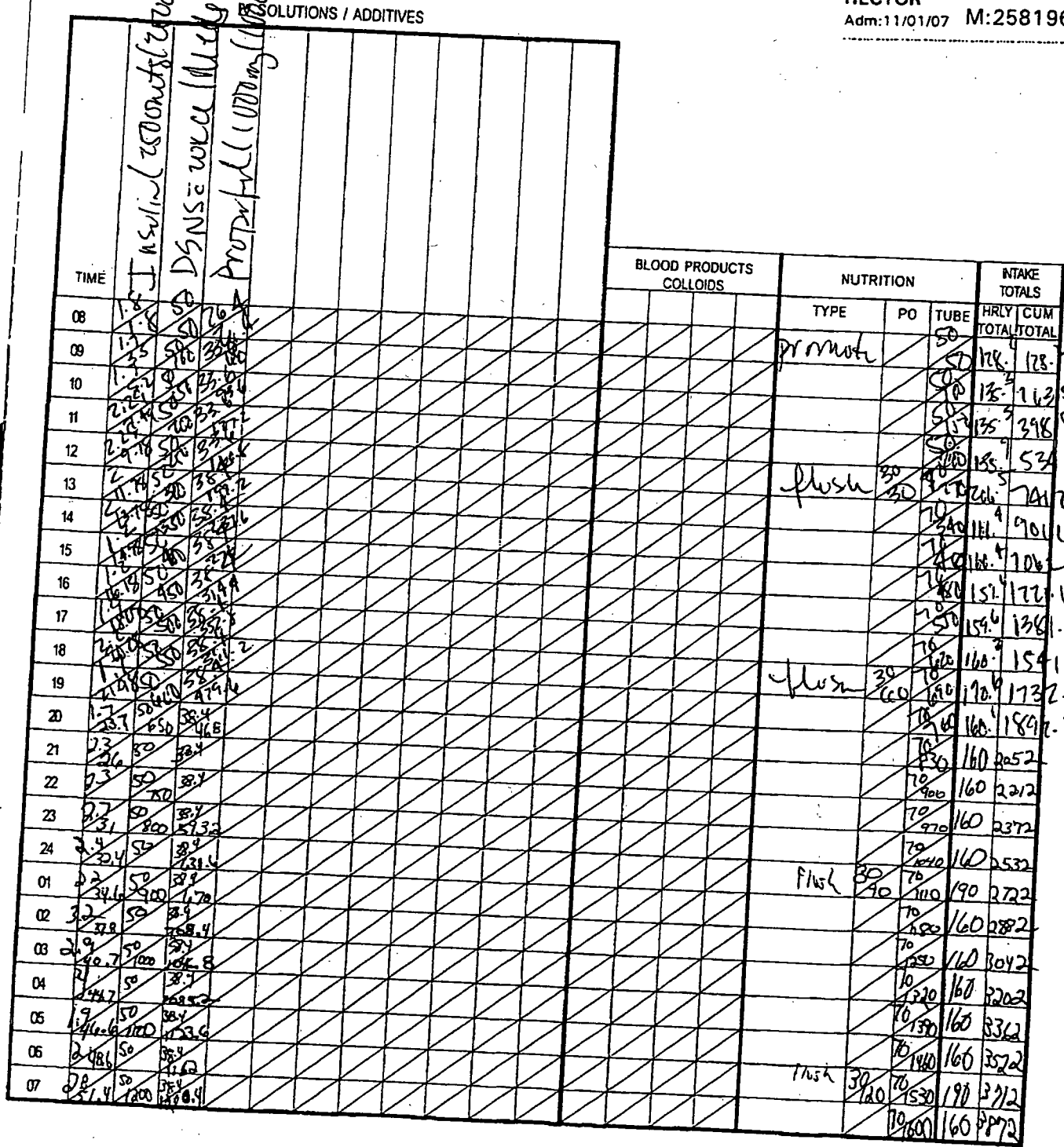
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page 2 of 12



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PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0730 Assumed care of pt. Report received. Assessment complete & noted. Meds given. 0930 Q Charge noted. 1130 Q Charge noted. 1330 Q Charge noted. 1530 Q Charge noted. 1730 Pt turned / Linens changed. 1900 Report given to oncoming RN

1910 Pt report received. Chart/MAR reviewed. 1920 Assessment complete meds given. Pt follows some commands at this time, though not consistently. Pt moves all extremities spont, localizes to pain. Pt grimacing at this time, see MAR. 2200 No changes noted. 0000 No changes noted. 0300 No changes noted. 0500 No changes noted. 0700 No changes noted. 0700 Report given to oncoming RN, pt left attended. JAN

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STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY		STOOL	EMESIS	OG/NG	RESID			
08	700	700	700							
09	850	150	150							
10	900	50	50							
11	1125	225	225							
12	1350	175	175							
13	1600	300	300							
14	2100	500	500							
15	2275	175	175							
16	2475	200	200							
17	2550	75	75							
18	2725	175	175							
19	2925	200	200							
20	3065	140	140							
21	3265	200	200							
22	3465	200	200							
23	3730	265	265							
24	3880	150	150							
01	3980	100	100							
02	4230	250	250							
03	4330	100	100							
04	4430	200	200							
05	4736	306	306							
06	4938	202	202							
07	5038	100	100							

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page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☐ Allergy band on
- ☐ Call system accessible
- ☑ Bed in low position
- ☐ Bed brakes on ☐ Bed alarms on
- ☐ On ☐ Off reason: _____
- ☐ Bed heel pressure relief
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☑ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ History of falls
  - ☐ Withdrawal from addictive substances
  - ☐ Violent behavior
  - ☐ Previous use of restraints
  - ☐ Other _____
- ○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/dx	Documented orthostatic hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:				
TOTAL POINTS:		☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE			0800		
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					
TRACH CARE	1700		0600		
BATH	1700				
FOLEY / PERI CARE	1700				
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE	1700		Partial 0630		
SKIN CARE	1700				
PEG SITE CARE	1700				
TYPE OF DIET					
% EATEN					
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 4 of 12

TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES			HEMATOLOGY					CHEMISTRY									
TYPE O_2 DEL	MODE / RATE	FIO_2 / TV	PEEP / PS	CPAP / PIP	MIN VENT		A/V / PH	PO_2 / PCO_2	HCO_3 / O_2SAT	HCT / HGB	WBC / RBC	PT / PTT	PLT / INR		NA / K	CL / CO_2	GLUC / BUN	CREAT / CA	MG / PHOS		FSBS	
BLW																							08
							7.42	93 / 37	23.9 / 97.5													11	09
																					136		10
																					135		11
																							12
																					115		13
																					116		14
																					124		15
																					132		16
																					114		17
																					118 .03		18
																					117 .04		19
																					116		20
																					104		21
																					114		22
																					101		23
																					118		24
							7.43	126 / 38	21.7 / 99	21.7 / 9.5	704 / 33		377		135 / 36	107 / 24	96 / 12	1.5 / 8.2	2.2 / 3.4		92		01
																					96		02
																					102		03
																							04
																							05
																							06
																							07

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VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/13/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(A) Hmn	DI	0800	
P	S	(P) FEMA	I	2000	(P) BR/WF

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: DLC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	(A) SC	S	DI	(A) +
P	(P) SC	S	I	(P) +

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

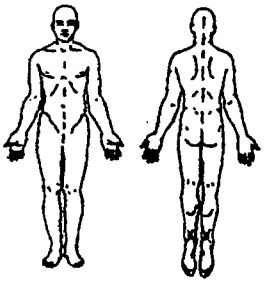
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



☐ Any problems identified, implement Comfort section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☑ Psychosocial / Spiritual / Education		M
☑ Comfort		M
☑ Neurologic / EENT		M
☑ Safety		M
☑ Functional / Musculoskeletal		M
☑ Skin / Wound		M
☑ Cardiovascular		M
☑ Respiratory		M
☑ Gastrointestinal		M
☑ Genitourinary		M
☑ Nutrition		M
☐ Discharge Planning		
☐ Other _____		

ASSESSMENT SIGNATURE GRID

	SIGNATURE	TIME
AM SHIFT ASSESSMENT		0800
PM SHIFT ASSESSMENT	RN	2000

* N R S R E C R D *

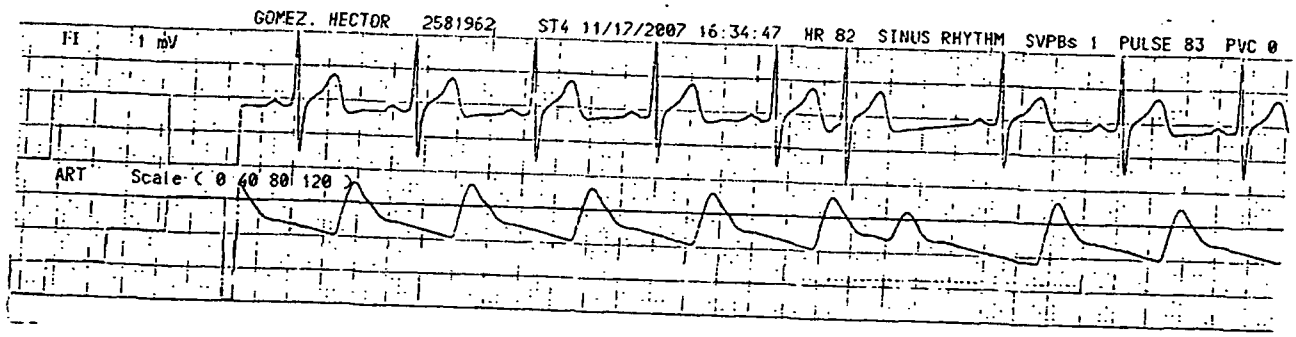
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page 5 of 12

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THIS SPACE MONITOR STRIPS



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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 8 of 12

GASTROINTESTINAL

☐A ☐P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM 11/15/07

Abnormal Findings

Bowel sounds
☐A ☐P Hyperactive
☐A ☐P Hypoactive
☐A ☐P Absent

Abdomen
☐A ☐P Firm ☐A ☐P Guarded
☐A ☐P Distended ☐A ☐P Tender
☐A ☐P Nausea ☐A ☐P Vomiting
☐A ☐P Girth (cm)_____
☐A ☐P Hernia, site_____

Bowel habits
☐A ☐P Incontinent
☐A ☐P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐A ☐P Poor dentition ☐A ☐P Stomatitis
☐A ☐P Lesions ☐A ☐P Thrush

GI tubes/drains ✓=placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT						
Small bore feeding tube						
G-tube	✓	✓	H	F	H	F
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

O Any problems identified, implement **GastroIntestinal** section of the **POC.**

GENITOURINARY

☐A ☐P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐A ☐P Menses

Abnormal Findings

Voiding patterns
☐A ☐P Incontinent ☐A ☐P Dysuria
☐A ☐P Bladder distention ☐A ☐P Unable to void
☐A ☐P Frequency/Urgency

Urine characteristics
☐A ☐P Oliguria ☐A ☐P Polyuria
☐A ☐P Anuria ☐A ☐P Cloudy
☐A ☐P Amber ☐A ☐P Hematuria
☐A ☐P Foul odor
☐A ☐P Other_____

Tubes / devices
☐A ☐P Condom ☐A ☐P Foley
☐A ☐P Suprapubic
☐A ☐P Nephrostomy ☐R ☐L
☐A ☐P Ureterostomy ☐R ☐L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A_____ P_____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐A ☐P Problematic pains or vaginal bleeding or discharge
☐A ☐P Concerns about sexual function
☐A ☐P Gravid (if yes, complete **Uterine/Fetal** section)
O Any problems identified, implement **GenitourinarY** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐A ☐P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
O Document any variations from normal limits in progress notes.

Postpartum Delivery date _____
☐A ☐P SVD
☐A ☐P C/Section
☐A ☐P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
O Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐A ☐P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness								
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐A ☐P Tingling
☐A ☐P Numbness Location _____

Devices Site / Type
☐A ☐P SCD/foot pump _____
☐A ☐P TED
☐A ☐P Traction Plast Fuse
☐A ☐P Cast/splint _____
☐A ☐P External fixator _____
☐A ☐P Other _____

Speech
☐A ☐P Slurred ☐A ☐P Unable to verbalize
☐A ☐P Aphasic ☐A ☐P Difficulty swallowing
O Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐A ☐P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐A ☐P Pale ☐A ☐P Cyanotic ☐A ☐P Jaundice
Turgor ☐A ☐P Loose ☐A ☐P Tight
Temperature ☐A ☐P Cool ☐A ☐P Diaphoretic

Skin Impairments

Location
☐A ☐P Surgical incision Sutured
dressing type/appearance Gauze
☐A ☐P Drain L Lateral
☐A ☐P Drain
☐A ☐P Wound
dressing type/appearance Wet to Moist
☐A ☐P Other
☐A ☐P Other

Wound vac™

	Location	mmHg	Suction
A			
P			

O Any problems identified implement **Skin/Wound** section of the **POC.**

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HECTOR
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(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 17 2007

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	00	02	04	06
Suction/cough / Secretions	V Th Tn						S Th T					
HOB>30 degrees unless contraindicated	SH						PW					
A line site ✓	SH						PW					
IV site ✓	SH						PW					
Chest tube patent ✓	N/A						NA					
NG/OG place ✓	PEG						PEG					
Mouth care	SH						PW					
Turn / Passive ROM	SH						PW					
Side Rails	SH						PW					
Incen. Spir./ deep breathe	SH						PW					
Alarms on / Assessment reviewed	SH	SH	SH	SH	SH	SH	PW	PW	PW	PW	PW	PW

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 17 2007

page 7 of 12

NEUROLOGIC / EENT

☐A ☐P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐A ☐P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐A ☐P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐A ☐P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐A ☐P Glasgow coma scale < 15 in non-sedated state.

☐A ☐P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	+1	+1	+1	+1
P	1	1	1	1

Reflexes Absent

☐A ☐P Cough ☐A ☐P Gag

☐A ☐P Corneal

Drainage

☐A ☐P Otorrhea ☐A ☐P Rhinorrhea

☐A ☐P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☐A ☐P Cervical collar Miami J

☐A ☐P Cervical traction

☐A ☐P Halo

☐A ☐P Tongs

☐A ☐P Shunt: _____

☐A ☐P Codman reference # _____

☐A ☐P Other _____

Impairments

☐A ☐P Hearing

☐A ☐P Eyes

☐A ☐P Unable to assess ETT

Fontanel

☐A ☐P Full ☐A ☐P Bulging

☐A ☐P Sunken

Emotional status

☐A ☐P Inconsolable

Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐A ☐P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☐A ☐P Arrhythmia SR

☐A ☐P Click

☐A ☐P S3

☐A ☐P Distant heart sounds

☐A ☐P S4

☐A ☐P Rub

☐A ☐P Capillary refill > 3 sec.

Murmur

☐A ☐P Faint

☐A ☐P Moderate

☐A ☐P Loud

☐A ☐P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A					
P					

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	+1	+2	+1	+1	
P	1	2	1	1	

Pacemaker / wires

☐A ☐P Permanent ☐A ☐P Transvenous

☐A ☐P Transcutaneous ☐A ☐P Epicardial

Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐A ☐P PA catheter

☐A ☐P AICD

Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐A ☐P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☐A ☐P: Suction functioning

☐A ☐P: Ambu bag/mask present

Abnormal Findings

Respirations

☐A ☐P Labored ☐A ☐P Shallow

☐A ☐P Irregular ☐A ☐P Orthopnea

☐A ☐P Stridor ☐A ☐P Pleural rub

☐A ☐P Accessory muscle use

☐A ☐P Chest excursion asymmetrical

Tracheal deviation

☐A ☐P Right ☐A ☐P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	D	D	D	D	D
P	R	R	R	R	R

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	Shiley	8.0	WNL	
P	Shiley	8	WNL	

☐A ☐P Emergency trach supply box

☐A ☐P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

Any problems identified, implement **Respiratory** section of the POC.

UP# 411230 rev 8/03

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/08

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 6 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.6mg Not: .5 mg

Date	Time	
11/1/07		STICU LIN
	7:22	S: Alert, Dr. Acute Events O/N
		O: 99.0 / 94 / 147/60(106) 12 I/O 2470/3429 100% Bacon #40 P T 20 0 7 1
		Awake, tracks, Moves 4/4 Extrem,
		S1 S2
		Coarse BS
		Abdom BSO Soft NT/ND
		Labs 6.9 / 6.9 / 33.5 / 29.9 BS 107 / 3.6 / 33 / 0.6 / 110 / 4.2 / 4.2 ABG, 7.42/39/93/94/24
		A/P 72yo MVC (Crash Accident c/p [redacted], Skull fx) + Necrotic 1st digits s/p amputations
		Neuro: Sedated, Arousable, Last montor
		Resp: Trach Secretions: Dark brown, Tan, moderate, tracheal, 93% on FIO2 40%
		PEN: Pantoprazole QD, IVF @ 50 per NOP, continue to Replace Electrolytes
		MSK: Necrotic 1st two digits
		ID: WBC to from 7.3 → 6.9, Afebrile, + Old Lung Enterobacter 11/1 (+)
		= Microculture, if pt spikes will restart Zosyn or Tazocin
		GI - Tf and NPO

[redacted]
1530

prgrecrd1

OTE 700222 Rev. 9/08

PRGRECRD

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero:
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/7/07		Ortho: S: intubated (sedated) O: R toes 2-4 black gangrenous change no signs of infection A/P: plan for metatarsal amputation with plantar flap when gangrenous change stabilized [signature] MD
11/17/07	1 pm	ORTHO - Staff Tracheostomy, sedated, ventilated, No response to command Afeb. (R) foot relatively unchanged. Toes 2-4 necrotic distal to PIP jt (+) DP pulse. (+) sent mmt A/P Skull/cranial fx, pneumo, vent dependent, (R) 2-4 toes c dry gangrene s/p crush injury - Cont ICU support for pulm/neuro issues. - Will need distal transmetatarsal amputation (poss. mid-transverse) - Would like to proceed in next wk as his tissue has begun to stabilize. [signature]

prgrecrd1

OTE 700222 Rev. 9/06

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Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5091528

MRN: 002581962
Date Exam Completed: 11/18/2007 04:05
Last Update: 11/19/2007

EXAMINATION: CHEST 11/18/07 04:05:00

ACCESSION NUMBER: 5091528

INDICATION: possible pneumonia

COMPARISON: 11/17/07

FINDINGS: Single frontal radiograph of the chest demonstrates tracheostomy and a left sided central venous catheter with distal tip overlying the cavoatrial junction. The cardiomediastinal silhouette is unchanged. Lungs demonstrate left basilar airspace opacity, likely combination of atelectasis and effusion. Right midshaft clavicular fracture with half shaft displacement again noted.

IMPRESSION:

1. Lines and tubes as above.
2. Right midshaft clavicular fracture with half shaft displacement again noted.
3. Left basilar opacity, likely combination of atelectasis and effusion, but may represent pneumonia.

VOICE DICTATED BY: Dr. Mike Hanley
I have reviewed the images and agree with the findings in this report.

History: possible pneumonia

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5091528

MRN: 002581962
Date Exam Completed: 11/18/2007 04:05
Last Update: 11/19/2007

Technologist: LORI RAGER
Interpreter 1: ABID IRSHAD
Interpreter 2: MIKE HANLEY
Interpreter 3:
Date Dictated:

Proxy Signer:

Authenticating Radiologist: ABID IRSHAD
Date Authenticated: 11/19/2007

Transcribed by: Tech IntTalk

NRSRECRD

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 8 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

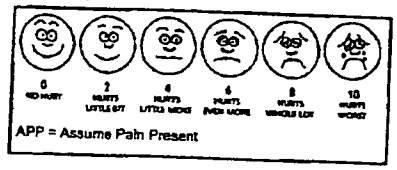
VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #

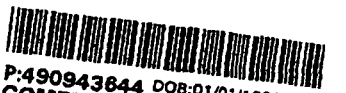




TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / RCWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN / SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR R	MOTOR L	VERBAL EYES
08	100	96	17		152/73	91					100				3	5	R	C	5	5	T 2
09		99	17		126/	91					98										
10		94	14		121/	86					96										
11	96	92	18		110/65	83					96										
12	98	90	18		118/	81					98										
13		87	17		119/	83					98				0	3	5	R	E	5	T 2
14		89	15		108/	79					98										
15		94	17		116/	79					96										
16	99	95	16		116/	82					97										
17		100	17		149/	100					96				0	3	5	B	5	5	T 2
18		116	17		136/	98					96		trach collar								
19	100	119	16		142/	105					96										
20	38	130	17		139/82	100					96										
21		126	19		137/82	99					95				0	4	5	B	5	6	T 4
22		132	19		149/88	108					96										
23	101	153	28		138/	105					96										
24	38	109	18 16		134/73	95					100				0	4	5	B	5	6	T 3
01		107	0 16		123/74	92					100										
02		102	0 16		120/80	94					100										
03		106	0 16		120/71	85					100										
04	38.2	104	0 16		130/78	95					100				0	4	5	B	5	6	T 3
05		103	4 16		124/78	92					100										
06		113	8 16		125/78	93					100										
07		110	6 16		102/61	77					100										

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 8 2007

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials

UP# 411230 rev 8/03

NRSRECRD

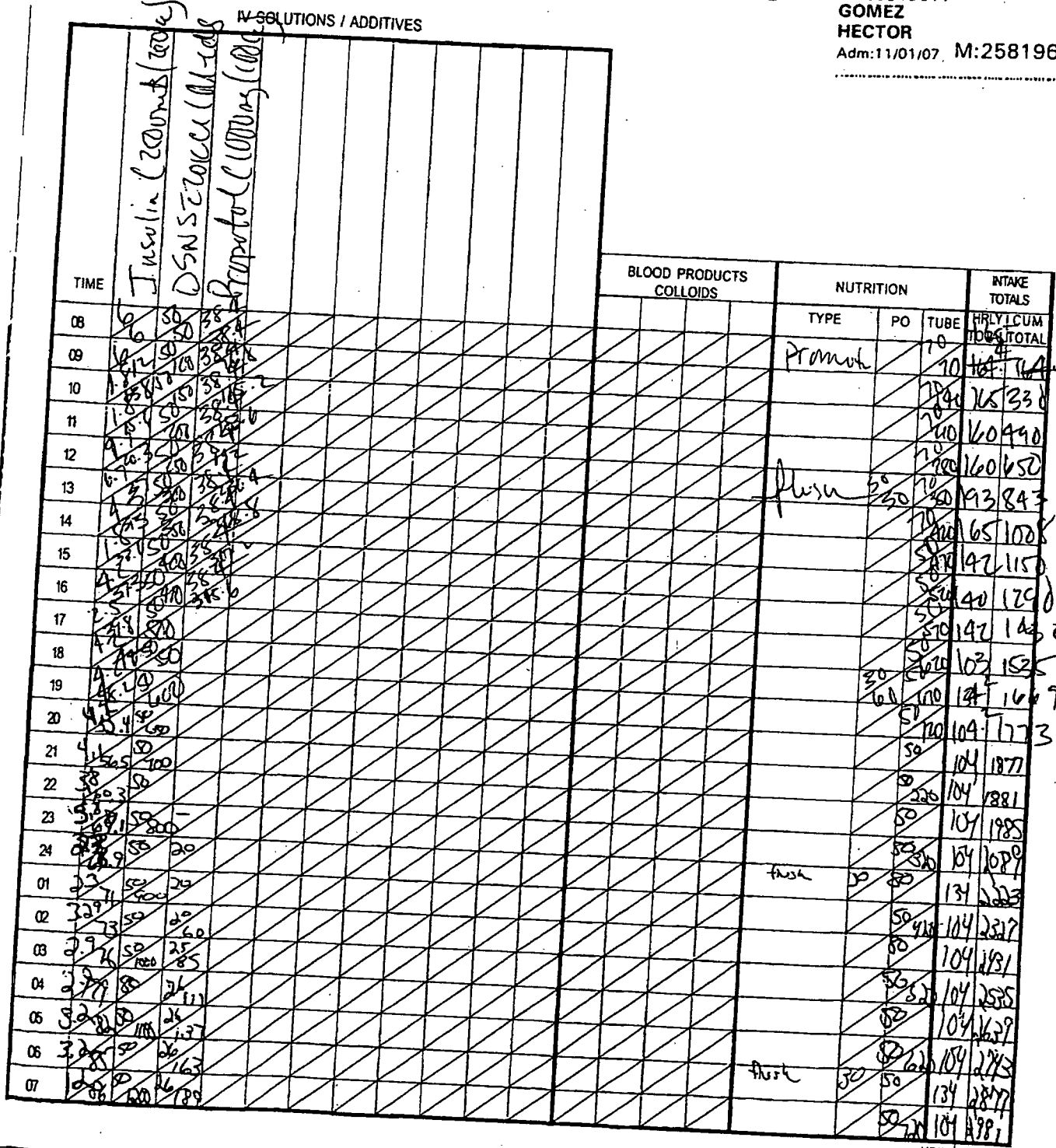
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NOV 18 2007

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 2 of 12

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page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0730 Assumed care of Pt. Report received Assessment completed & pt's Meds given 0920 @ Change date 1130 @ Change made 1334 @ Change write 1530 @ Change made 1800 Pt bathed Linen Changed Pt in Track collar VSS. 1940 Night fall to encourage pt @ 2110 Pt/report rec'd. Chart/MAR reviewed. 2009 Assessment Complete, meds given. Pt. c/o pain at this time, see MAR. 2330 Pt. severe Tachycardic rate 173, RR 41, ABP 173/93. Pt very Rhonchorous and agitated. Pt. placed on PRVC at this time, Lebetalol given. 2330 HR 117, RR 16, ABP 106/62, O2 sat 97 Pt also started on propofol at 2300. Pt shows no agitation at this time. 0110 Report given to oncoming RN Slumpt, Pt left taken by Pt

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* N R S R E C R D *

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24 HOUR CRITICAL CARE PATIENT RECORD

Date NOV 18 2007

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STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY		STOOL	EMESIS	OG/NG	RESID			
08	300	300	300							
09	600	300	300							
10	750	150	150							
11	800	50	50							
12	850	50	50							
13	900	50	50							
14	975	75	75							
15	1100	125	125							
16	1250	150	150							
17	1350	100	100							
18	1450	100	100							
19	1550	100	100							
20	1730	180	180							
21	1880	150	150							
22	2080	200	200							
23	2280	200	200							
24	2380	100	100							
01	2505	125	125							
02	2655	150	150							
03	2855	200	200							
04	3130	275	275							
05	3330	200	200							
06	3530	200	200							
07	3730	200	200							

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24 HOUR CRITICAL CARE PATIENT RECORD

Date NOV 18 2007

page 10 of 12

SAFETY

- ☑ Hospital ID band on
- ☐ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position
- ☐ Bed brakes on
- ☑ Bed alarms on
- ☑ Bed heel pressure relief
- ☐ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status
  - ☐ Violent behavior
  - ☐ History of falls
  - ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances
  - ☐ Other _____
- ○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:				
TOTAL POINTS:		☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done; RA = right arm; LA = left arm; RL = right leg; LL = left leg; IJ = internal jugular; EJ = external jugular; SC = subclavian; RF = right femoral; LF = left femoral

IV INSERT TYPE/SIZE LOCATION					
IV SITE CARE LOCATION					
IV TUBING CHANGE					
PICC LIMB CIRCUMFERENCE					
A-LINE SITE CARE					2030
TRACH CARE	1800 q				
BATH	1800 SU				
FOLEY / PERI CARE	1800 SU				
FOLEY D/C'd					
STRAIGHT CATH					
LINEN CHANGE	1800 q				
SKIN CARE	1800 q				
PEG SITE CARE	1800 q				
TYPE OF DIET					
[illegible]	CVL DSG				2030
PACING WIRES INSULATED SECURED					
SPECIALTY BED					

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* N R S R E C R D *

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page 4 of 12

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TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION					BLOOD GASES			HEMATOLOGY				CHEMISTRY								
TYPE O_2 DEL	MODE / RATE	FIO_2 / TV	PEEP / PS	CPAP / PIP	MIN VENT	A/V / PH	PO_2 / PCO_2	HCO_3 / O_2SAT	HCT / HGB	WBC / RBC	PT / PTT	PLT / INR	NA / K	CL / CO	GLUC / BUN	CREAT / CA	MG / PHOS		FSBS	
																			145	08
																				09
																			116	10
																				11
																			127	12
																			154	13
																			132	14
																			95	15
																			146	16
																			101	17
						T-A 10 945 48 39.9													120	18
																			111	19
																			114	20
																			105	21
PRN																				22
																			124	23
																			118	24
																			89	01
																			107	02
3LPM																			99	03
																				04
																			105	05
																			89	06
																				07

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Adm:11/01/07 M:2581962
(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/13/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	RW Rem	DI	0810	
P	S	RW Rem	I	2000	(+) WF/BR

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: DLC Insert Date: 11/1/07

	Site	Appearance	Dressing	Blood Return
A	DSC	S	DI	+
P	DSC	S	I	+

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

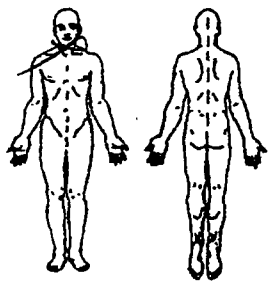
Abnormal Findings

☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(A) Pain Score: _____ Patient Goal: _____
(P) Pain Score: 6 Patient Goal: 0-3

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling



Location of pain (on the diagram, put an X on the area where the patient complains of pain)

☐ Any problems identified, implement Comfort section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☐ Psychosocial / Spiritual / Education		M
☐ Comfort		M
☐ Neurological / EENT		M
☐ Safety		M
☐ Functional / Musculoskeletal		M
☐ Skin / Wound		M
☐ Cardiovascular		M
☐ Respiratory		M
☐ Gastrointestinal		M
☐ Genitourinary		M
☐ Nutrition		M
☐ Discharge Planning		
☐ Other		

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE _____ TIME 0800

PM SHIFT ASSESSMENT
SIGNATURE _____ TIME 2000

UP# 411230 rev 8/03

NRSRECRD

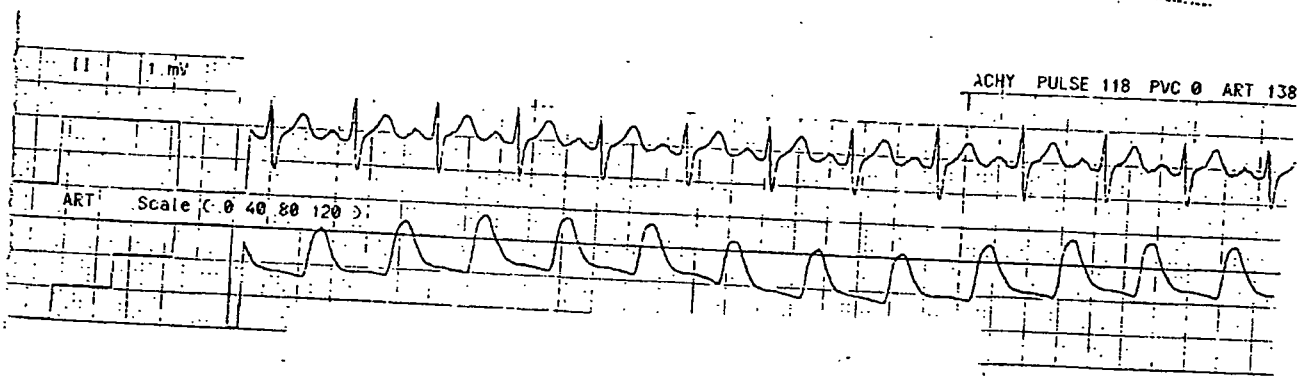
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 18 2007

page 5 of 12

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

THIS SPACE MONITOR STRIPS



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inted by COL9

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GASTROINTESTINAL

☐A ☐P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM 11/15/07

Abnormal Findings

Bowel sounds
☐A ☐P Hyperactive
☐A ☐P Hypoactive
☐A ☐P Absent

Abdomen
☐A ☐P Firm ☐A ☐P Guarded
☐A ☐P Distended ☐A ☐P Tender
☐A ☐P Nausea ☐A ☐P Vomiting
☐A ☐P Girth (cm)
☐A ☐P Hernia, site

Bowel habits
☐A ☐P Incontinent
☐A ☐P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐A ☐P Poor dentition ☐A ☐P Stomatitis
☐A ☐P Lesions ☐A ☐P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT						
Small bore feeding tube						
G-tube	✓	✓				
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

○ Any problems identified, implement **Gastrointestinal** section of the POC.

GENITOURINARY

☐A ☐P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐A ☐P Menses

Abnormal Findings

Voiding patterns
☐A ☐P Incontinent ☐A ☐P Dysuria
☐A ☐P Bladder distention ☐A ☐P Unable to void
☐A ☐P Frequency/Urgency

Urine characteristics
☐A ☐P Oliguria ☐A ☐P Polyuria
☐A ☐P Anuria ☐A ☐P Cloudy
☐A ☐P Amber ☐A ☐P Hematuria
☐A ☐P Foul odor
☐A ☐P Other

Tubes / devices
☐A ☐P Condom ☐A ☐P Foley
☐A ☐P Suprapubic
☐A ☐P Nephrostomy ☐R ☐L
☐A ☐P Ureterostomy ☐R ☐L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A P

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐A ☐P Problematic penile or vaginal bleeding or discharge
☐A ☐P Concerns about sexual function
☐A ☐P Gravid (if yes, complete **Uterine/Fetal** section)
○ Any problems identified, implement **Genitourinary** section of the POC.

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐A ☐P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date
☐A ☐P SVD
☐A ☐P C/Section
☐A ☐P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐A ☐P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness	✓	✓	✓	✓	✓	✓	✓	✓
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐A ☐P Tingling
☐A ☐P Numbness Location

Devices Size / Type
☐A ☐P SCD/foot pump BLE
☐A ☐P TED
☐A ☐P Traction Pins Hoz
☐A ☐P Cast/splint
☐A ☐P External fixator
☐A ☐P Other

Speech
☐A ☐P Slurred ☐A ☐P Unable to verbalize
☐A ☐P Aphasic ☐A ☐P Difficulty swallowing
○ Any problems identified, implement **Functional / Musculoskeletal** section of the POC.

SKIN / WOUND

☐A ☐P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐A ☐P Pale ☐A ☐P Cyanotic ☐A ☐P Jaundice
Turgor ☐A ☐P Loose ☐A ☐P Tight
Temperature ☐A ☐P Cool ☐A ☐P Diaphoretic

Skin Impairments
☐A ☐P Surgical incision Location Sutures-Mid
dressing type/appearance + Intact
☐A ☐P Drain
☐A ☐P Drain
☐A ☐P Wound Black necrotic
dressing type/appearance
☐A ☐P Other
☐A ☐P Other TCS

Wound vac™

	Location	mm Hg	Suction
A			
P			

○ Any problems identified implement **Skin/Wound** section of the POC.

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 8 2007

page 6 of 12

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	00	02	04	06
Suction/cough / Secretions	Th Th						S Th T					
HOB>30 degrees unless contraindicated	SH						PN	PN				
A line site ✓	SH						PN					
IV site ✓	SH						PN					
Chest tube patent ✓	N/A						N/A					
NG/OG place ✓	N/A						N/A					
Mouth care	SH						PN					
Turn / Passive ROM	SH						PN					
Side Rails	SH						PN					
Incen. Spir./ deep breathe	SH						PN					
Alarms on / Assessment reviewed	SH	SH	SH	SH	SH	SH	PN					

UP# 411230 rev 8/03

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NOV 18 2007

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HECTOR
Adm:11/01/07 M:2581962
(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 7 of 12

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA.

☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.
☐ A ☐ P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	+1	+1	+1	+1
P				

Reflexes Absent
☐ A ☐ P Cough ☐ A ☐ P Gag
☐ A ☐ P Corneal

Drainage
☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea
☐ A ☐ P Eye
1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices
☐ A ☐ P Cervical collar Miami J
☐ A ☐ P Cervical traction
☐ A ☐ P Halo
☐ A ☐ P Tongs
☐ A ☐ P Shunt: _____
☐ A ☐ P Codman reference # _____
☐ A ☐ P Other _____

Impairments
☐ A ☐ P Hearing
☐ A ☐ P Eyes
☐ A ☐ P Unable to assess ETT

Fontanel
☐ A ☐ P Full ☐ A ☐ P Bulging
☐ A ☐ P Sunken

Emotional status
☐ A ☐ P Inconsolable

Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart
☐ A ☐ P Arrhythmia SA
☐ A ☐ P Click
☐ A ☐ P S3
☐ A ☐ P Distant heart sounds
☐ A ☐ P S4
☐ A ☐ P Rub
☐ A ☐ P Capillary refill > 3 sec.

Murmur
☐ A ☐ P Faint
☐ A ☐ P Moderate
☐ A ☐ P Loud
☐ A ☐ P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A					1
P					

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	+1	+1	+1	+1	
P	+1	+2	+1	+1	

Pacemaker / wires
☐ A ☐ P Permanent ☐ A ☐ P Transvenous
☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial
Temporary pacer mode: _____

	Rate A	Rate V	mA A	mA V	Sensitivity A	Sensitivity V
A						
P						

☐ A ☐ P PA catheter
☐ A ☐ P AICD

Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☐ A ☐ P: Suction functioning
☐ A ☐ P: Ambu bag/mask present

Abnormal Findings

Respirations
☐ A ☐ P Labored ☐ A ☐ P Shallow
☐ A ☐ P Irregular ☐ A ☐ P Orthopnea
☐ A ☐ P Stridor ☐ A ☐ P Pleural rub
☐ A ☐ P Accessory muscle use
☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation
☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUA	RML	RLA	LUA	LLA
A					
P					

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A				
P	Shiley	8.0	WNL	

☐ A ☐ P Emergency trach supply box
☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage
S=serous; SS=serosanguinous; B=bloody; P=purulent
Air leak / SQ emphysema
P=present; A=absent

Location	Suction amt or H_2O Seal A	Suction amt or H_2O Seal P	Drainage A	Drainage P	Air Leak A	Air Leak P	SQ emphysema A	SQ emphysema P

Any problems identified, implement **Respiratory** section of the POC.

UP# 411230 rev 8/03

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/5/07	5:30	STICU Progress Note No events overnight 99.1 125 17 149/83 93% on trach collar I: 3872 TF@70 O: 5030 min SSI Gen: awake, trach collar sounds, overall ref. PS 5/5 NS @ 20cc/hr CV: RRR, nl S1S2, no murmurs Propofol Resp: CTA(B) Lorazepam Abd: (+) BS, soft, NT, ND Albuterol Ext: SCDs in place Haldol Ptravidil 135 / 107 / 12 / 82 / 95 / 222 3.6 / 29 / 0.5 / 84 / 29.7 A/P 27 y/o HM s/p CHI from coma is excellent, stable, ① neuro: sedated, arousable, contin to monitor ② resp: trach collar trial today, will ✓ SBO ③ CV: RRR, wdly hemodynamics ④ FEN: D5 ½NS @ 50cc/hr, TF @ 70, electrolytes replaced per protocol ⑤ prophylaxis: Lovenox for DVT prophylaxis, SCDs MD 8693

prgrecrd1

OTE 700222 Rev. 9/06

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Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5091855

MRN: 002581962
Date Exam Completed: 11/19/2007 04:27
Last Update: 11/19/2007

EXAMINATION: CHEST, 11/19/07 04:27:00

ACCESSION NUMBER: 5091855

INDICATION: crane accident, CHI. respiratory insufficiency

COMPARISON: 11/18/07

FINDINGS: Single frontal radiograph of the chest demonstrates stable support lines and tubes. Stable size and contour of the cardiomediastinal silhouette. There is a left basilar opacity likely representing atelectasis with associated pleural effusion, unchanged from prior study. There is no evidence of pneumothorax. Visualized portions of the bony thorax demonstrate a right clavicular fracture unchanged from prior study.

IMPRESSION:

1. Left basilar opacity likely atelectasis with associated pleural effusion, unchanged from prior study.
I have reviewed the images and agree with the findings in this report.

History: crane accident, CHI

Technologist: GENE BRUNSON
Interpreter 1: JAMES RAVENEL
Interpreter 2: MELISSA PICCARD
Interpreter 3:

Proxy Signer:

Authenticating Radiologist: JAMES RAVENEL
Date Authenticated: 11/19/2007

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:38 AM
Printed by: LINCOLN, COURTNEY

Date Dictated:

Transcribed by: Tech IntTalk

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

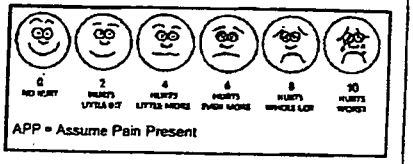
VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

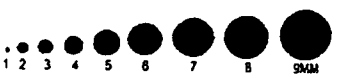
PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #



APP = Assume Pain Present



TIME	TEMP	PULSE	SPON VENT RESP	CUFF BP	A-LINE BP	MAP PCWP	CVP	PA	CO CI	SVR	S,O,	ICP HI LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL EYES
08	37.4	103	29		148/82	100					100			0	4	4	B	B	6	4
09		111	20		134/78	97					98									
10		121	21	129/77		90					100									
11		113	22	126/80		82					100									
12	37.0	109	21	145/105		92					100			0	4	4	B	B	6	4
13		105	17	140/55		82					100		ABG ☑							
14		118	27	153/88		88					100									
15		114	22	129/74		87					100									
16	37.3	109	19	131/75		88					100			0	4	4	B	B	6	4
17		115	24	145/78		94					100									
18		130	20	150/		91					100									
19		131	21	159/101		90					98		insulin off ☑							
20	98.8	124	17	144/65		85					100									
21		114	15	132/57		82					100			0	4	4	B	B	6	4
22		121	23	142/		94					98									
23		121	19	127/76		89					92									
24	98.5	119	24	130/62		78					97									
01		115	25	142/74		93					94			0	4	4	B	B	6	4
02		112	13	132/77		92					96									
03	98.7	109	17	134/79		87					94									
04		108	26	120/80		92					97									
05		103	16	135/50		73					96			0	4	4	B	B	6	4
06		116	28	139/85		91					93									
07		100	17	133/76		88					93									

UP# 411230 rev 8/03

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HECTOR
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
Amy Featherman RN 7a-7p	AF		
Kate Sullivan, RN 7p-7a	KS	[illegible] RN 5pm-7am	[illegible]

UP# 411230 rev 8/03

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	Insulin 1 unit/ml	NS + 20 mEq KCl	NS Flush	BLOOD PRODUCTS COLLOIDS	NUTRITION Meds			INTAKE TOTALS	
					TYPE	PO	TUBE	HRLY TOTAL	CUM TOTAL
08	1.7	50	3		promote	100	50	165	165
09	3.8	100	3				50	167	232
10	3.3	70	3				50	166	298
11	1.9	80	3				50	164	362
12	4.3	90	3				50	117	479
13	3.9	100	3			30	70	86	565
14	4.1	110	3				70	87	652
15	3.4	120	3				70	86	738
16	3.9	130	3				70	87	825
17	2.7	140	3				70	86	911
18	2.8	150	3			30	70	116	1027
19	4.5	160	3			120	70	83	1110
20	off	170	3			100	70	186	1296
21		180	3			120	70	83	1379
22		190	3				70	83	1462
23		200	3				70	83	1545
24		210	3				70	113	1658
01		220	3			30	70	83	1741
02		230	3			120	70	83	1824
03		240	3				70	83	1907
04		250	3				70	83	1990
05		260	3				70	80	2070
06		270	3			30	70	110	2180
07		280	off			120	70	80	2260

Total = 2260

UP# 411230 rev 8/03

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NOV 19 2007

24 HOUR CRITICAL CARE PATIENT RECORD Date _____
page 11 of 12

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Time: Record changes in patient's status and patient/family education

PROGRESS NOTES

0720 Report received from PM RN, standards of care reviewed, plan of care cont. 0745 Assessment comp. as noted, pt. follows commands @ bed pt. agitated-2 mg haldol and 2 mg dilaudid IV given, insulin gtt infusing per protocol, RT @ BS- pt. placed on trach collar, will cont. to monitor. 0900 A-line d/c'd d/t malfunction no other Δ's. 1045 CC team @ BS for rounds, orders received + noted. 1230 NO Δ's @ this time. 1400 NO Δ's 1600 NPH orders received + noted, no other Δs. 1800 insulin drip d/c'd per MD order. 1910 report given to PM RN, pt. left attended.

1920 Report received from off-going RN, chart reviewed + drips verified. Care of pt assumed. VS 2000 Alarms on, assessment completed, documented per flowsheet. Spanish interpreter at bedside, pt follows commands x all extremities, denies c/o pain. Pt ST, lungs rhonchorous in upper lobes, pt T/P SIIx q dilaudid BS Ø2x4, frequent thick. Will monitor. VS 2200 Pt suctioned - SAT 92-93%. Dr. Brown in & notified. Pt denies any pain. VS 2300 T for to 50's VS 0120 Pt resting. VS. VS 0320 Labs sent. VS

0400 Report received orders reviewed. Agree & assessment documented. will continue to monitor. 0500 Haldol and dilaudid given see MAR Pt agitated 0515 0% pain pt resting, report given to oncoming RN orders reviewed, left attended.

UP# 411230 rev 8/03

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

page 3 of 12

P:490943644 DOB:01/01/1951 L M
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Adm:11/01/07 M:2581962

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

	OUTPUT		URINE	GASTRIC				CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
TIME	CUM	HOURLY		STOOL	EMESIS	OG/NG	RESID			
08	350	350	350				Ø			
09	660	310	310							
10	935	275	275							
11	1015	180	180							
12	1240	225	225				Ø			
13	1365	125	125							
14	1490	125	125							
15	1615	125	125							
16	1750	135	135				Ø			
17	1850	100	100							
18	1975	125	125							
19	2085	110	110							
20	2085	50	50				15			
21	2210	125	125							
22	2335	125	125							
23	2415	80	80							
24	2415	60	60							
01	2515	100	100							
02	2615	50	50							
03	2850	235	235							
04	2970	120	120				10			
05	3120	150	150							
06	3195	75	75							
07	3255	60	60							

Total = 3255

UP# 411230 rev 8/03

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

page 10 of 12

SAFETY

- ✓ Hospital ID band on
- ✓ Call system accessible
- ✓ Bed in low position
- ✓ Bed heel pressure relief
- ✓ IV solutions verified
- ✓ IV tubing/bag dated
- ✓ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☐ Allergy band on
- ✓ Bed brakes on ☐ Bed alarms on
- ✓ On ☐ Off reason: _____

☐ Patient at high risk for infection
☐ Immunocompromised ☐ Other _____
☐ Patient assessed for placing self or others at risk that may require restraint usage
☐ Cognitive impairment/altered mental status ☐ Violent behavior
☐ History of falls ☐ Previous use of restraints
☐ Withdrawal from addictive substances ☐ Other _____
○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/tx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:	0	2	2	0
TOTAL POINTS:	4	☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION						
IV SITE CARE LOCATION						
IV TUBING CHANGE						
PICC LIMB CIRCUMFERENCE						
A-LINE SITE CARE	dkd 0900					
TRACH CARE	1500 DR					
BATH	1500 DR					
FOLEY / PERI CARE	1500 DR					
FOLEY D/C'd					/	
STRAIGHT CATH						
LINEN CHANGE	1500 DR					
SKIN CARE						
PEG SITE CARE	1500 DR					
TYPE OF DIET	TF				TF	
% EATEN					70 after 2400	
PACING WIRES INSULATED SECURED					N/A	
SPECIALTY BED	ICU				KCI	
Miami J pads Δ'd	1500 DR					

UP# 411230 rev 8/03

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 4 of 12

P:490943644 DOB:01/01/1951 L M
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TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION						BLOOD GASES				HEMATOLOGY					CHEMISTRY								
TYPE O2 DEL	MODE RATE	FiO2	TV	PEEP PS	CPAP PIP	MEN VENT	A/V PH	PO2 PCO2	HCO3 O2SAT		HCT HGB	WBC RBC	PT PTT	PLT INR	NA K	CL CO2	GLUC BUN	CREAT CA	MG P-IOS	FSBS		
T		40%					7.41	83 42	25.9 100.2											140 4.4	0700	08
																				107 4.0	07	09
																				78	07	10
																				122	06	11
																				107	07	12
							7.31	48	25.8											111	07	13
								43	99.5											103	08	14
																				107	08	15
																				99	08	16
																				100	07	17
																						18
TC		40%																				19
																				140		20
																						21
		50%																				22
																						23
																				131		24
																						01
							A 7.41	85 42	22.2 97.1	33.4 11	98 3.8	141			139 4.2	103 24	132 9	0.5 93	23 35			02
																				132		03
																						04
																						05
																						06
																						07

UP# 411230 rev 8/03

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NOV 19 2007

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: 11/13/07

	Appearance	Location	Dressing	Calibrated Time	
A	S	(+) femr.	DI	0945	(+) wave
P	S		DI		

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing		
A					
P					

Line #1 Type: DLC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	(+) SC	S	DI	(+)
P	SC	S	DI	(+)

Line #2 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

Abnormal Findings

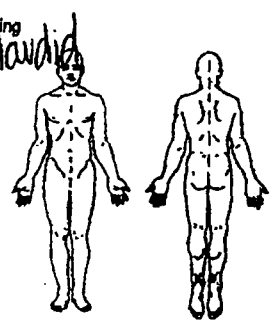
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☒A ☐P Receiving analgesic therapy prn attending

(A) Pain Score: 7 Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐A ☐P New ☐A ☐P Ongoing

Pain Description
☐A ☐P Dull ☐A ☐P Constant
☐A ☐P Burning ☐A ☐P Cramping
☐A ☐P Stabbing ☐A ☐P Radiating
☐A ☐P Throbbing ☐A ☐P Tingling

Location of pain (on the diagram, put an X on the area where the patient complains of pain)



● Any problems identified, implement Comfort section of the POC.

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☒ Psychosocial / Spiritual / Education	M	M
☒ Comfort	M	M
☒ Neurologic / EENT	M	M
☒ Safety	M	M
☒ Functional / Musculoskeletal	M	M
☒ Skin / Wound	M	M
☒ Cardiovascular	M	M
☒ Respiratory	M	M
☒ Gastrointestinal	M	M
☒ Genitourinary	M	M
☒ Nutrition		M
☐ Discharge Planning		
☐ Other		

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE: Heatherm Mann RN TIME: 0945

PM SHIFT ASSESSMENT
SIGNATURE: Kane Sellars, RN TIME: 2000

UP# 411230 rev 8/03

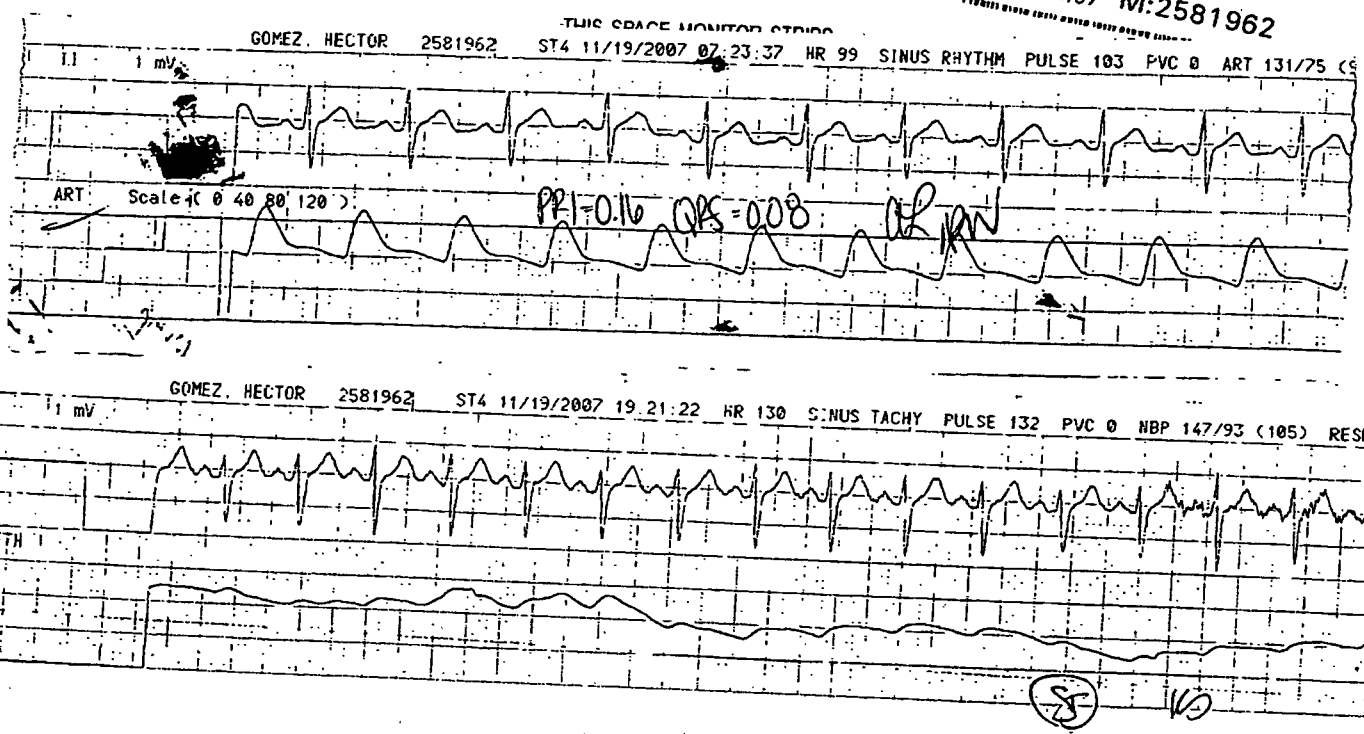
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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 9 2007

page 5 of 12

P:490943644 DOB:01/01/1951 L M
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HECTOR
Adm:11/01/07 M:2581962



UP# 411230 rev 8/03

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(STAMP PLATE)

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

page 8 of 12

GASTROINTESTINAL

☐A ☐P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM 11/15/07

Abnormal Findings

Bowel sounds
☐A ☐P Hyperactive
☒A ☐P Hypoactive
☐A ☐P Absent

Abdomen
☐A ☐P Firm ☐A ☐P Guarded
☐A ☐P Distended ☐A ☐P Tender
☐A ☐P Nausea ☐A ☐P Vomiting
☐A ☐P Girth (cm)
☐A ☐P Hernia, site

Bowel habits
☐A ☐P Incontinent
☐A ☐P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐A ☐P Poor dentition ☐A ☐P Stomatitis
☐A ☐P Lesions ☐A ☐P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location A	✓ / location P	Suction A	Suction P	Drainage A	Drainage P
NGT						
OGT						
Small bore feeding tube						
G-tube	✓	✓ (Round)	–	–	F	F
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

● Any problems identified, implement **Gastrointestinal** section of the POC.

GENITOURINARY

☐A ☐P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐A ☐P Menses

Abnormal Findings

Voiding patterns
☐A ☐P Incontinent ☐A ☐P Dysuria
☐A ☐P Bladder distention ☐A ☐P Unable to void
☐A ☐P Frequency/Urgency

Urine characteristics
☐A ☐P Oliguria ☐A ☐P Polyuria
☐A ☐P Anuria ☐A ☐P Cloudy
☐A ☐P Amber ☐A ☒P Hematuria
☐A ☐P Foul odor
☐A ☐P Other

Tubes / devices
☐A ☐P Condom ☒A ☐P Foley
☐A ☐P Suprapubic
☐A ☐P Nephrostomy ☐R ☐L
☐A ☐P Ureterostomy ☐R ☐L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A P

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐A ☐P Problematic penile or vaginal bleeding or discharge
☐A ☐P Concerns about sexual function
☐A ☐P Gravid (if yes, complete **Uterine/Fetal** section)
● Any problems identified, implement **Genitourinary** section of the POC.

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐A ☐P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date
☐A ☐P SVD
☐A ☐P C/Section
☐A ☐P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐A ☐P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm A	R Arm P	L Arm A	L Arm P	R Leg A	R Leg P	L Leg A	L Leg P
Limited ROM								
Weakness								
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐A ☐P Tingling
☐A ☐P Numbness Location

Devices Site / Type
☒A ☒P SCD foot pump (B) LE
☐A ☐P TED
☐A ☐P Traction
☐A ☐P Cast/splint
☐A ☐P External fixator
☒A ☐P Other pins (R) foot

Speech
☐A ☐P Slurred ☒A ☐P Unable to verbalize
☐A ☐P Aphasic ☐A ☐P Difficulty swallowing
● Any problems identified, implement **Functional / Musculoskeletal** section of the POC.

SKIN / WOUND

☐A ☐P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐A ☐P Pale; ☐A ☐P Cyanotic; ☐A ☐P Jaundice
Turgor ☐A ☐P Loose; ☐A ☐P Tight
Temperature ☐A ☐P Cool; ☐A ☐P Diaphoretic

Skin impairments
☒A ☐P Surgical incision Location sutures - head
dressing type/appearance
☐A ☐P Drain
☐A ☐P Drain
☒A ☐P Wound (R) toe black
dressing type/appearance Iodine
☐A ☐P Other
☐A ☐P Other

Wound vac™

	Location	mmHg	Suction
A			
P			

● Any problems identified implement **Skin/Wound** section of the POC.

UP# 411230 rev 8/03

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

page 6 of 12

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive Secretions Codes: Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20	22	24	02	04	06
Suction/cough / Secretions	S Th,W	S Th,W	S Th,W	S Th,W	S Th,W	S Th,W	S Th,W	S Th,W	S Th,W	S Th,W	S Th,W	S Th,W
HOB>30 degrees unless contraindicated	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
A line site ✓	✓	N/A	—	—	—	—	N/A	—	—	—	—	—
IV site ✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	—
Chest tube patent ✓	N/A	—	—	—	—	—	N/A	—	—	—	—	—
NG/OG place ✓	PEG	—	—	—	—	—	PEG	—	—	—	—	—
Mouth care	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Turn / Passive ROM	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	
Side Rails	X2	X2	X2	X2	X2	X2	TX2	TX2	TX2	TX2	TX2	X2
Incen. Spir./deep breathe	self	self	self	self	self	self	TURN	TURN	TURN	TURN	TURN	self
Alarms on / Assessment reviewed	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	

UP# 411230 rev 8/03

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

NOV 19 2007

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 7 of 12

NEUROLOGIC / EENT

☐A ☐P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present.

☐A ☐P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.

☐A ☐P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA

☐A ☐P **WNL:** Fontanel soft and flat

Abnormal Findings

☒A ☐P Glasgow coma scale < 15 in non-sedated state. follow commands @times

☐A ☐P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A				
P	1	1	1	1

Reflexes Absent

☐A ☐P Cough ☐A ☐P Gag

☐A ☐P Corneal

Drainage

☐A ☐P Otorrhea ☐A ☐P Rhinorrhea

☐A ☐P Eye

1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices

☒A ☐P Cervical collar Miami J

☐A ☐P Cervical traction

☐A ☐P Halo

☐A ☐P Tongs

☐A ☐P Shunt: _____

☐A ☐P Codman reference # _____

☐A ☐P Other _____

Impairments

☐A ☐P Hearing

☐A ☐P Eyes

☒A ☐P Unable to assess ↳ pain

Fontanel

☐A ☐P Full ☐A ☐P Bulging

☐A ☐P Sunken

Emotional status

☐A ☐P Inconsolable

● Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐A ☐P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart

☒A ☐P Arrhythmia ST

☐A ☐P Click

☐A ☐P S3

☐A ☐P Distant heart sounds

☐A ☐P S4

☐A ☐P Rub

☐A ☐P Capillary refill > 3 sec.

Murmur

☐A ☐P Faint

☐A ☐P Moderate

☐A ☐P Loud

☐A ☐P Absent if expected in congenital defects

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P	WNL	dry			

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A					
P					trace

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A					
P	+2	+2	+2	+2	

Pacemaker / wires

☐A ☐P Permanent ☐A ☐P Transvenous

☐A ☐P Transcutaneous ☐A ☐P Epicardial

Temporary pacer mode: _____

	Rate A	Rate V	mA A	mA V	Sensitivity A	Sensitivity V
A						
P						

☐A ☐P PA catheter

☐A ☐P AICD

● Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐A ☐P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.

☒A ☐P: Suction functioning

☒A ☐P: Ambu bag/mask present

Abnormal Findings

Respirations

☐A ☐P Labored ☐A ☐P Shallow

☐A ☐P Irregular ☐A ☐P Orthopnea

☐A ☐P Stridor ☐A ☐P Pleural rub

☐A ☐P Accessory muscle use

☐A ☐P Chest excursion asymmetrical

Tracheal deviation

☐A ☐P Right ☐A ☐P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A	R	R	D	R	D
P	R	R	D	R	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	T	8.0	WNL	
P	T	8.0	WNL	

☒A ☐P Emergency trach supply box

☒A ☐P Oral airway at bedside

Chest Tubes / Drains

Drainage

S=serous; SS=serosanguinous; B=bloody; P=purulent

Air leak / SQ emphysema

P=present; A=absent

Location	Suction amt or H_2O Seal A	Suction amt or H_2O Seal P	Drainage A	Drainage P	Air Leak A	Air Leak P	SQ emphysema A	SQ emphysema P

● Any problems identified, implement **Respiratory** section of the POC.

UP# 411230 rev 8/03

PRGRECRD

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/19	0745	STICU PROGRESS NOTE
		(S) No new events o/N
		(O) 38.4 110 22 10 3/2L 100% 248//4080
		GEN: Awake, alert, follows commands Insulin 8u
		CV: RRR S MRR D5NS c KCl @50 72.00
		Resp: crackles R>L acceptable expansion, trach intact
		GI: SINTIND/+BS PEG intact
		EXT: normal pulses, SCDs in place
		~~LABS 138/105/11/115 3.7/27/0.8/ 9.0 7.2 8.5 9.5 40~~ 741/42/43/26 on TC
		(A/P) 27 y/o HM SIP crane accident, skull fx
		(1) CV: cont. monitoring vitals, H/H stable
		(2) Resp: Trach collar trials, CPAP vs. PRVC
		(3) Neuro: holding sedation, awake, alert
		(4) FEN: D5 1/2 @ 50
		(5) Prophylaxis: SCD's, tomorrow
		(6) ortho: (2) toe necrotic, awaiting demarcation, amputation

needs: combivent tomorrow

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HECTOR
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ATTENDING PHYSICIAN NOTE

MRN: _____

NAME: _____

Date: 11/19/07 Service: Trauma

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to _____

Upon personally questioning the patient, I can confirm that the following are the key history factors:

Physical Examination: Pulse: 110 BP: 102/61 Resp Rate: 22 T: 98.4/97.4 Input: 2981 Output: 4080

Neuro: Alert. Attempts to communicate.
Eyes: PERRL
ENT: Trach site OK.
CV: RRR. No m g r. Hct 9.5
Resp: Sats 100% Currently on trach collar 341/42/83
GI/Nutr: Tolerating tube feeds
GU/Renal: Good UOP. Labs WNL
MuscSkel: C collar in place. No changes in foc neuros. No evidence of wet gangrene
Skin:
Psych: Quite agitated
Other:

☑ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☐ I have personally reviewed pertinent X-ray examinations.
☑ I have personally reviewed the results of additional medical testing and monitor output.
☐ I have personally discussed the case with _____

Diagnoses/Problems

1.	Skull fx.	☐New	☐Improved	☑Unchanged	☐Worsening
2.	CVA	☐New	☐Improved	☐Unchanged	☐Worsening
3.	C2-T1 S.P. fx	☐New	☐Improved	☐Unchanged	☐Worsening
4.	C6 Clavicle fx	☐New	☐Improved	☐Unchanged	☐Worsening
5.	Multiple C6 Metatarsal fxs	☐New	☐Improved	☐Unchanged	☐Worsening
6.	Scalp laceration	☐New	☐Improved	☐Unchanged	☐Worsening

Management Options/Recommendations Neurosurg fxs

1. D/C tube feeds to gastric
2.
3.
4.
5.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☑High

☐ Pt is critically ill/injured. I spent _____ minutes providing critical care to this patient.

Overall Condition: ☐Critical ☑Serious ☐Fair ☐Good

_____ Signature Date 11/19/07

UMA #19100-13 revised 11/06

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

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Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/19/07	4:10 pm	Nutrition F/u - Pt s/p PEG + trach. D/C'd propofol this am. S/p frontal skull fx 2/2 CHI. Labs 11/19 138 | 105 | 17 (↓ 105) WBC 8.45 (9 / 3) 3.7 | 27 | 105 11/16: triglyceride 202 Meds - Noted Δed from insulin gtt to NPH (34 units BID) TF: promote @ 50mL/hr c 2 pkts prostat while pt on propofol. (1820 kcals + 105g pro → 27 kcal/kg + 1.6g pro/kg c propofol calories) plan - ① Monitor labs, wt, I/Os ② Δ TF to promote @ 70mL/hr (D/C prostat) Now that pt off propofol. 1680 kcals + 105g protein 25 kcal/kg + 1.6 g pro/kg. ③ F/u + acyl sat levels pm. Amy J Berry RD CNSD 1-2733

prgrecrd1

OTE 700222 Rev. 9/06

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: **GOMEZ-FRAGOSO, HECTOR**
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5093177

MRN: 002581962
Date Exam Completed: 11/20/2007 03:13
Last Update: 11/20/2007

EXAMINATION: CHEST, 11/20/07 03:13:00

ACCESSION NUMBER: 5093177

INDICATION: crane vs person scalp injury. pt on trach collar with improved resp status want to determine if edema improved

COMPARISON: 11/19/07

FINDINGS: Single frontal radiograph of the chest demonstrates stable support lines and tubes. Stable size and contour of the cardiomediastinal silhouette. There are low lung volumes. Again noted is a left basilar opacity likely atelectasis with associated pleural effusion, unchanged from prior study. There is no evidence of pneumothorax. Visualized portions of the bony thorax again demonstrate a right clavicular fracture.

IMPRESSION:

1. Low lung volumes with left basilar atelectasis and associated pleural effusion.

I have reviewed the images and agree with the findings in this report.

History: crane vs person scalp injury

Technologist: GAY MARTIN
Interpreter 1: PHILIP COSTELLO
Interpreter 2: MELISSA PICCARD

Proxy Signer:

Authenticating Radiologist: PHILIP COSTELLO

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:37 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CHEST PORTABLE 1 VIEW
Accession #: 5093177

MRN: 002581962
Date Exam Completed: 11/20/2007 03:13
Last Update: 11/20/2007

Interpreter 3:
Date Dictated:

Date Authenticated: 11/20/2007

Transcribed by: Tech IntTalk

NRSRECRD

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 20 2007

page 1 of 12

(STAMP PLATE)

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY #

APP = Assume Pain Present

1 2 3 4 5 6 7 8 9MM

TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP HI / LOW	DAILY WEIGHT / TIME / LOSS/GAIN	PAIN / SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR	VERBAL	EYES
08	37.4	101	14	111/57		71					96			0	4	4	B	B	6	T	4
09		92	14	121/59		72					96										
10		130	18	138/81		78					94										
11		127	22	143/88		100					98										
12	37.2	114	17	159/83		98					93										
13		133	16	133/69		83					94			4	4	B	4	B	6	T	4
14		129	24	126/66		80					93										
15		135	23	149/69		80					92		OT @ BS								
16	37.0	119	21	117/46		100					92										
17		125	22	125/58		89					92			0	4	4	B	4	B	6	T	4
18		123	21	135/71		80					99										
19		114	17	139/87		89					100										
20	37.2	104	18	140/52		87					100										
21		104	11	117/68		77					100		PRN glucn	4	4	B	4	B	6	T	4
22		101	12	124/61		77					100										
23	37.1	104	12	124/65		79					100										
24		106	18	131/82		93					100										
01		102	18	132/69		80					100			3	4	B	4	B	6	T	4
02		117	15	140/66		83					99										
03		113	11	99/76		87					96										
04	37	95	16	116/69		78					100		Linen Δ'd	0	4	4	B	4	B	6	T	4
05		110	15	101/70		80					100										
06		112	17	113/69		74					100										
07		93	11	110/64		74					100										

UP# 411230 rev 8/03

PRGRECRD

MUSC
THERAPEUTIC SERVICES
Discovering. Understanding. Healing.

Medical University Hospital Authority
Rehab Services
Charting Report

NAME: GOMEZ, HECTOR **PAT** 490943644 **MRN** 002581962

Date/Time: 11/20/2007 3:08:00PM Patient Room/Bed at Time of Encounter: 4STN:4STN/04

Orders Completed:

Occupational Therapy Evaluation

Referring Physician: Doug Norcross, MD(A); **Start of Care:** 11/20/2007
Funding: FX

Reason for referral: OT Evaluation and Treatment

Medical Diagnosis: CHI
History of Illness: A 27-year-old Hispanic male who was working at a construction site as per report, the counterweight of the crane fell on his head. He has a left scalp laceration, intubated.
As per report, he was combative at the scene and had some vomiting. His wound was cleaned and sutured by the trauma service. Among other injuries, he has right big toe fracture, right fifth toe fracture, right clavicle fracture.

11/02/2007 - 1. Irrigation and debridement of open fracture of phalanges (skin to bone).
2. Closed reduction and percutaneous pinning of hallux second, third,
and fifth toe proximal phalanx fractures
3. Nailbed repair fourth and fifth toes

11/15/2007 - Placement of percutaneous endoscopic gastrostomy tube.

Previous Medical History: Unknown

Evaluation Location: ICU No Family present

Special Conditions/Precautions: tracheostomy, NPO, restraints, peg tube, pulse ox, IV, telemetry, Foley Catheter, O2 via trach collar, Sequential Compression Devices, NWB, bedrest,

Barriers to Learning: Pain, Cognition, Language,

Social History:
Marital Status: Single
Occupation: construction
Function PTA: Assumed independent
Living situation/support: Pt. able to indicate that he lives in an apartment in Myrtle Beach with 5 other people
Equipment at home: Unable to obtain

Activity Status: Bedrest

Communication: able to communicate basic needs through gestures, head nods or mouthing words

Cognition:
Behavior: cooperative fatigued lethargic appropriate
Orientation: self, hospital,

PRGRECRD

Rehab Charting Report Continued

NAME: GOMEZ, HECTOR **PAT** 490943644 **MRN** 002581962

Ability to follow directions: Inconsistent
Attention: Impaired
Memory: unable to assess
Insight and judgement: Will continue to assess during ADL tasks

AROM: Limited right shoulder due to clavicle fracture. Left UE AROM WFL

PROM: Limited right shoulder flexion due to clavicle fx; otherwise, PROM is WFL

BUE Strength: bilateral elbows and hands strength adequate to perform simple self care

Coordination: Unable to assess

Endurance: Unable to assess

BUE Sensation: Intact for light touch

Activities of Daily Living: Unable to formally assess
Grooming:
Feeding:
Bathing:
UE Dressing:
LE Dressing:
Toileting:

Mobility: Uanble to assess due to pt. on bedrest
Rolling:
Supine <-> sit:
Sitting EOB:
Scooting up in bed:
Scooting EOB:
Transfer to chair/BSC:

Pain: (0 - 10 pain scale): Pt. unable to give pain rating.

Equipment Used: No equipment issued at this time, will continue to assess.

Education Provided: Role of OT,

Assessment: Pt. is a 27 y.o. Hispanic male who was working at a construction site as per report, the counterweight of the crane fell on his head. He has a left scalp laceration, intubated.
As per report, he was combative at the scene and had some vomiting. His wound was cleaned and sutured by the trauma service. Among other injuries, he has right big toe fracture, right fifth toe fracture, right clavicle fracture.

After evaluation, pt. is presenting with the following:
- decreased ability to perform ADL's and functional transfers,
- limited ROM in right shoulder ,
- Decreased overall cognitive skills,

Patient would benefit from OT to address the above listeddeficits and assist pt. with increasing overall function. Will continue to assess for d/c needs.

Plan of care: (*May include but not limited to)
ADL's, Functional Mobility Training, Therapeutic Exercise, Family Education, DME recommendations and adaptive



Rehab Charting Report Continued

NAME: GOMEZ, HECTOR	PAT 490943644	MRN 002581962

equipment,

Patient's Goals: Unable to formally assess

Patient participation in goal selection: Caregiver not available to participate in goals.

Short term goals: (1 week) -
1. **Pt. will be able to attend 10 minute ADL task**
2. **Pt. will wash face with set-up and cueing using washcloth**
3. **Pt. will transfer supine to sit MAX ASSIST**

Long term goals: Will establish at later date

OT Rehabilitation Potential: Good

Treatment frequency and duration: 2 - 4 x/week

Recommendations: Will continue to assess.

Equipment Recommendations: No equipment needed at this time, will continue to assess.
Electronically Signed by: Josie Craig, OTR/L

If you received this report in error, please notify the MUSC Compliance Office immediately at (843) 792-4037 or 1-800-296-0269. Thank you.

********** Confidential Notice **********
This report is intended only for the use of the individual or entity to which it is addressed and may contain information that is privileged, confidential, and exempt from disclosure. If the reader of this report is not the intended recipient or an employee responsible for delivering the report to the intended recipient, you are hereby notified that any disclosure, dissemination, distribution, or copying of this report is strictly prohibited.

PRGRECRD

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

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USE: 5 mg NOT: 5.0 mg
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USE: 0.5mg Not: .5 mg

Date	Time	
11/20	745	STICU PROGRESS
		(S) 0 events o/n
		(O) 98^8 98^7 100 12 133/66 98% 2260//3255
meds		TC 50%
consolvent		GEN: Alert, awake, follows commands NS +20cc/hr IO
Colace		CV: RRR S mkg, palp pulses Protein 70
Lovenox		Resp: CTAB. Trach intact
SSI		ABD: S/NT IND/+BS
NPH		EXT: RLE necrosis of toes
Senna		
ABX		LABS: 137/103/9 (103 9.3/2.7/3.5 9.8) 11/324 (491 7.42/43/85/22
Heparin d/c'ed		4.2/28/0.5
		(A/P) 27 y/o HM S/P crush accident
		(1) CV/Resp: Stable at present c TC, Cont. monitoring
		(2) Neuro: agitated, PRN haldol/d/c'ed need 1/1a; awake, alert
		(3) FEN: feeds @ goal via PEG, BM's, residuals
		(4) Prophy: lovenox, SCD's
		(5) ORTHO: (R) toes necrotic, awaiting amputation, Ortho following
		(6) Disp: possibly to step down today

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OTE 700222 Rev. 9/06

"PRGRECRD"

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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/20/07		Orthop.
		No acute event, extubated.
		Alert and follows commands
		(R 2-5 toes dry gangrenous changes, No signs of infection
		Rec: plan for metatarsal or proximal phalangeal amputation when wound stabilized
		[signature]
		1530

prgrecrd1

OTE 700222 Rev. 9/06

PRGRECRD

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HECTOR
Adm:11/01/07 M:2581962

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ATTENDING PHYSICIAN NOTE

MRN: ___
NAME: ___

Date: 11/20/07 Service: Trauma

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to intub
Upon personally questioning the patient, I can confirm that the following are the key history factors:

Physical Examination: Pulse: 92 BP: 121/57 Resp Rate: 14 T: afeb Input: 2760 Output: 3255

Neuro: Sedate. Follows commands
Eyes: PERRL
ENT: Endotube ok.
CV: RRR. No M G or R
Resp: Clear bilat 242/43/85 on ac/ps TC
GI/Nutr: Tolerating tube feeds @ goal rate
CU/Renal: Voiding UO.
MuscSkel: C/C/C in place.
On Lovenox.
Skin: Ecchymosis remains dry
Psych: A bit bis inappropriate
Other: WBC of 9.5

☑ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☐ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☐ I have personally discussed the case with ___

Diagnoses/Problems

1.	cHI - blat frontal lobe contusion	☐New	☑Improved	☐Unchanged	☐Worsening
2.	Skull Fx	☐New	☐Improved	☑Unchanged	☐Worsening
3.	(R) Comp fx	☐New	☐Improved	☑Unchanged	☐Worsening
4.	(R) Clav fx	☐New	☐Improved	☑Unchanged	☐Worsening
5.	(A) pneumothorax c tube in place	☐New	☐Improved	☑Unchanged	☐Worsening
6.	Cath sepsis	☐New	☐Improved	☑Unchanged	☐Worsening

Management Options/Recommendations

1. Perform swallow eval
2. OT consult
3. Wean Fio2 as tolerated
4.
5.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☐High
☐ Pt is critically ill/injured. I spent ___ minutes providing critical care to this patient.
Overall Condition: ☐Critical ☐Serious ☐Fair ☐Good

Signature Date 11/20/07

UMA #19100-13 revised 11/06

prgrecrd1

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"PRGRECRD"

MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
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Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/20	0923	OT Consult received. Chart reviewed. Eval completed. Report to follow. Thank you Julie Cruz, OTR/L 12338
11/21/07		STICU/CC
	0730	No events o/n.
		37.4 37° 93 110/64 100% TC 50% FiO2
		T/O: 2080: TF@70 // 1685
		Awake, alert, nonverbally responsive, FCx4
		PERL
		RRR: 1/6 SEM
		Lungs CTA
		Trach #8 patent + secure
		Abd S, NT/ND, +BS, PEG site c/d/i
		(R) toe necrosis, unchanged
		7.4/47/103/98.1%/50% FiO2 - TC 9 11 3 49.7 142 106 15 109 2.4 9.7 4.1 30 0.5 4.7
		MIS 27yo HM s/p head injury, (R) foot crush injury ① Neuro - ↓ issues ② CV - ↓ trauma H+H stable ⑧ Dispo: Possibly to stepdown ③ Resp - Wean FiO2. Pneumb ↑ PRN Q6 ④ GI - TF @ goal. Speech consult ⑦ ⑤ Ext - to ortho OR for amputation @ some time ⑥ Prophy - lovenox, SCDs, Pepcid ⑦ ID - Consider d/c central line. PPD placed. 15320

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NRSRECRD

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NOV 21 2007

24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 1 of 12

COMA SCALE

MOTOR
6 Obeys commands (normal spontaneous movement for peds)
5 Localizes to pain
4 Withdraws to pain
3 Abnormal flexion to pain
2 Abnormal extension to pain
1 No response

VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response

P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

EYES
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

SEDATION-AGITATION SCALE
7 Dangerous agitation
6 Very Agitated
5 Agitated
4 Calm, cooperative
3 Sedated
2 Very sedated
1 Unarousable

ICU DAY # _____

0 NO HURT | 2 HURTS LITTLE BIT | 4 HURTS LITTLE MORE | 6 HURTS EVEN MORE | 8 HURTS WHOLE LOT | 10 HURTS WORST

APP = Assume Pain Present

1 2 3 4 5 6 7 8 9MM

TIME	TEMP	PULSE	SPON / VENT RESP	CUFF BP	A-LINE BP	MAP / PCWP	CVP	PA	CO / CI	SVR	S_vO_2	ICP Hi / LOW
08	36	109	18	126/70		80					100	
09		103	11	HR 68		72					100	
10		116	10	133/71		84					100	
11		104	10	144/72		94					100	
12	37	107	11	11							96	
13		115	17	135/71		87					96	
14		108	13	131/71		87					99	
15		114	11	136/71		80					100	
16	37	103	17	110/67		77					100	
17		93	12	110/64		77					100	
18		97	12	115/68		77					100	
19		114	13	126/68		75					98	
20	99.1	110	11	132/67		96					100	
21												
22												
23												
24												
01												
02												
03												
04												
05												
06												
07												

DAILY WEIGHT _____
TIME _____
LOSS/GAIN _____

Bath. Linen

PAIN / SEDATION	PUPILS SIZE R	PUPILS SIZE L	PUPILS REACTION R	PUPILS REACTION L	MOTOR R	MOTOR L	VERBAL	EYES
0	4	B	4	2	6	6	1	3
4								
0	4	B	4	3	6	6	1	4
0	3	4	B	4	B	6	1	3
4								
2	4	B	4	B	6	6	T	4

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24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 12 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

Signature / Shift	Initials	Signature / Shift	Initials
Ashley Penn CCRN TRACH		[illegible] RN 7p-7a	CJ

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page 2 of 12

IV SOLUTIONS / ADDITIVES

TIME	NS c 20K	BLOOD PRODUCTS COLLOIDS	NUTRITION TYPE	NUTRITION PO	NUTRITION TUBE	INTAKE TOTALS HRLY TOTAL	INTAKE TOTALS CUM TOTAL
08	10/10			30/30	70/40	110	110
09	10/20				70/140	80	190
10	10/30				70/210	80	270
11	10/40				70/280	80	350
12	10/50			30/60	70/350	110	460
13	10/60				70/420	80	540
14	10/70				70/490	80	620
15	10/80				70/560	80	700
16	10/90				70/630	80	780
17	10/100				70/700	110	890
18	10/110			30/90	70/770	80	970
19	10/120				70/840	80	1050
20	10/130				70/910	80	1130
21							
22							
23							
24							
01							
02							
03							
04							
05							
06							
07							

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24 HOUR CRITICAL CARE PATIENT RECORD Date ~~NOV 2 1~~ 2007
page 11 of 12

PROGRESS NOTES

Time: Record changes in patient's status and patient/family education

0700 Report received, Pt. care assumed. 0800 Pt. assessment Complete, no distress observed. Pt. awake & alert. MAE on command. Pt. Spanish speaking. Pt. c #8 Shiley on trach collar 40% - RR 1000 Speech c 35 - RR 1400 Pt. asleep - RR 1700 Pt. bathed & linens changed. RR 1845 Pt. resting & distress - RR 2015 Assumed Care. Pt awake & alert. Pt able to FCs & MAE's. (+) Pulses to (B) Lower Extremities. Pt. denies Pain when asked. "Spanish Spk'n" only. BIV. flushed & Patent. NLVF's infusing & difficult @ KVO. Pt is ST on monitor 100's. 100.0 TC @ 1400. All other VS's WNL. No S/Sx of Acute distress needed. Assessment Completed. Monitor alarms enabled. 2045 Report Called to 6W. Pt transferring to Rm 657. 2110 Pt. transferred to Rm 657. Condition remained stable - no events noted. Pt. left attended to & receiving RN - Kerri. Adult Nrsg transfer Report attached.

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page 3 of 12

STOOL AMOUNT
S = Small
M = Moderate
L = Large

DESCRIPTION
Br = Brown
L = Loose
F = Formed
H = Hard
Bld = Bloody
S = Seedy
M = Meconium
Blk = Black
G = Green
C = Clay
Y = Yellow

RESIDUAL
R = Returned
D = Discarded

Blood Tube Reference table

Color	Description	mL	Color	Description	mL
Blue top	small	1.8 mL	Gold	large	4 mL
Blue top	medium	2.7 mL	Red	blood	4 mL
Blue top	large	4.5 mL	Green		3 mL
Gray top		2 mL	Lavender	microtainer	0.5 mL
Lavender		2.5 mL	Green	microtainer	0.6 mL
Lavender	dark (blood bank)	4 mL	Red	microtainer	0.5 mL

TIME	OUTPUT CUM	OUTPUT HOURLY	URINE	GASTRIC STOOL	GASTRIC EMESIS	GASTRIC OG/NG	GASTRIC RESID	CHEST TUBES / DRAINS	BLOOD SAMPLES	COMMENTS
08	100	100	100							
09	140	40	40 140							
10	240	100	100 240							
11	315	75	75 315							
12	415	100	100 415							
13	480	75	75 480							
14	520	30	30 520							
15	670	150	DP 670							
16	745	75	75 745							
17	775	30	30 775							
18	875	100	100 875							
19	935	60	60 935							
20	1060	125	125 1060							
21										
22										
23										
24										
01										
02										
03										
04										
05										
06										
07										

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24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 21 2007

page 10 of 12

SAFETY

- ☑ Hospital ID band on ☐ Allergy band on
- ☑ Call system accessible
- ☑ Bed in low position ☑ Bed brakes on ☐ Bed alarms on
- ☑ Bed heel pressure relief ☑ On ☐ Off reason: _____
- ☑ IV solutions verified
- ☑ IV tubing/bag dated
- ☑ High alert medications identified
- ☐ Isolation type posted: ☐ Airborne ☐ Droplet ☐ Contact
- ☐ Patient at high risk for infection
  - ☐ Immunocompromised ☐ Other _____
- ☐ Patient assessed for placing self or others at risk that may require restraint usage
  - ☐ Cognitive impairment/altered mental status ☐ Violent behavior
  - ☐ History of falls ☐ Previous use of restraints
  - ☐ Withdrawal from addictive substances ☐ Other _____
- ○ Any risk criteria identified, implement the Safety section of the POC.

Fall Risk Assessment

Complete on patients ≥ 6 years. Circle appropriate response per category (one per row), then add total points.

Points	0	1	2	3
Age	< 59	60-70	71-80	81+
Mental Status	Oriented & cooperative	Comatose	Oriented & uncooperative; depressed	Confusion; short-term memory loss
Physical Status	New onset - admitted for acute episode/Dx	Documented ortho-static hypotension	Dizziness, vertigo, syncope	Cachexia and wasting
Elimination	Independent, continent	Catheter or ostomy	Elimination with assistance; diarrhea or incontinency	Independent and incontinent; urgency/frequency
Impairments	None	Visual, hearing, language/speech	Limb (e.g., amputation)	Neurological (e.g., paralysis, paresthesia)
Gait or Balance	Unable to walk/stand (not at risk), or fully ambulatory	Physically unable to walk/stand (but may attempt to)	Walks with help (e.g., mobility aids; cane, walker, furniture, etc.)	Balance problems - walking or standing; unsteady gait
History of falls in past 6 months	No history	Near falls or fear of falling	Has fallen 1 or 2 times	Multiple falls (e.g., more than 2X)
Medications* at present or prior to admission	None of the medications below	One of the medications below	Two of the medications below	Three or more of the medications below

* Circle: Alcohol, anesthetic, antihypertensive, antiseizure/antiepileptic, benzodiazepine, diuretic, cathartic, hypoglycemic, IV therapy, narcotic, psychotropic, sedative/hypnotic, other (specify) _____

SUBTOTAL:	0	2	0	3
TOTAL POINTS:	5	☐ N/A Patient < 6 years old		

0-5 points: Low Risk 6-10 points: Moderate Risk 10 or more points: High Risk

○ If score ≥ 6, implement Safety section of the POC.

Source: University of Texas, Medical Branch Hospitals, Galveston, Tx

PROCEDURES / TREATMENTS

INDICATE TIME PROCEDURE DONE

✓ = done IJ = internal jugular
RA = right arm EJ = external jugular
LA = left arm SC = subclavian
RL = right leg RF = right femoral
LL = left leg LF = left femoral

IV INSERT TYPE/SIZE LOCATION						
IV SITE CARE LOCATION	1720 LA					
IV TUBING CHANGE						
PICC LIMB CIRCUMFERENCE						
A-LINE SITE CARE						
TRACH CARE						
BATH	1700					
FOLEY / PERI CARE	1700					
FOLEY D/C'd						
STRAIGHT CATH						
LINEN CHANGE	1700					
SKIN CARE	1700					
PEG SITE CARE	1700					
TYPE OF DIET	TF					
% EATEN						
PACING WIRES INSULATED SECURED						
SPECIALTY BED						

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TYPE
T = T-Bar/Collar
M = Face mask
V = Ventilator
CPM = C Pap Mask
BMP = Bi Pap Mask
N = Nasal Cannula
H = Hood

MODE
AC = Assist Control
SIMV = Synchronized Intermittent Mandatory Ventilation
PC = Pressure Control
PS = Pressure Support
PRVC = Pressure Regulated Volume Control
J = Jet
OSC = Oscillator
VDR = Volume Diffuser Respirator

	VENTILATION					BLOOD GASES			HEMATOLOGY				CHEMISTRY							
TYPE O_2 DEL	MODE / RATE	FiO_2 / TV	PEEP / PS	CPAP / PIP	MIN VENT	AaV / PH	PO_2 / PCO_2	HCO_3 / O_2SAT	HCT / HGB	WBC / RBC	PT / PTT	PLT / INR	NA / K	CL / CO_2	GLUC / BUN	CREAT / CA	MG / PHOS	FSBS	
T		40																87	08
																			09
																			10
																			11
																		114	12
																			13
																			14
																			15
																		108	16
																			17
																			18
TC		40																	19
																		127	20
																		0	21
																			22
																			23
																			24
																			01
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																			03
																			04
																			05
																			06
																			07

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page 9 of 12

VASCULAR ACCESS

Appearance: S=Secure, D=Dislodged, E=Erythemic, L=Leaking, T=Tender
Dressing: I=Intact, D=Dry, W=Wet, L=Loose

Pulmonary artery catheter Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time	Measurement at Introducer
A					
P					

Arterial line Date inserted: / /

	Appearance	Location	Dressing	Calibrated Time
A				
P				

High Dose Heparin catheter Type: _____ Date inserted: / /

	Appearance	Location	Dressing
A			
P			

Line #1 Type: QLC Insert Date: 11/7/07

	Site	Appearance	Dressing	Blood Return
A	(L) FC	S	D/I	(-)
P				

Line #2 Type: PIV #20 Insert Date: 11/21/07

	Site	Appearance	Dressing	Blood Return
A				
P	(L) HAND	S	D/I	(-)

Line #3 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

Line #4 Type: _____ Insert Date: / /

	Site	Appearance	Dressing	Blood Return
A				
P				

COMFORT

☑ A ☐ P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

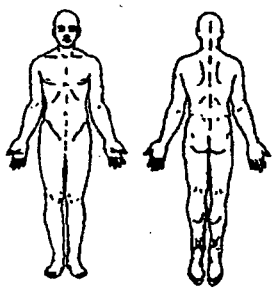
Abnormal Findings

☐ A ☐ P Nausea ☐ A ☐ P Itching ☐ A ☐ P Chills
☐ A ☐ P Fever ☐ A ☐ P Sweating ☐ A ☐ P Difficulty sleeping
☐ A ☐ P Pain ☐ A ☐ P Receiving analgesic therapy

(A) Pain Score: 0 Patient Goal: _____
(P) Pain Score: _____ Patient Goal: _____

Pain Onset ☐ A ☐ P New ☐ A ☐ P Ongoing

Pain Description
☐ A ☐ P Dull ☐ A ☐ P Constant
☐ A ☐ P Burning ☐ A ☐ P Cramping
☐ A ☐ P Stabbing ☐ A ☐ P Radiating
☐ A ☐ P Throbbing ☐ A ☐ P Tingling



Location of pain (on the diagram, put an X on the area where the patient complains of pain)

○ Any problems identified, implement **Comfort** section of the **POC.**

PLAN OF CARE (POC) EVALUATION

Check all active patient problems. Document outcome evaluation code every 12 hours.

Evaluation
R = Problem resolved. No interventions needed for past 24 hr, may D/C problem on POC.
M = Outcome met with interventions. No note required.
N = Outcome not met. Revise plan as needed. Note required.
U = Unable to assess.

	A	P
☐ Psychosocial / Spiritual / Education	M	
☑ Comfort	M	M
☐ Neurologic / EENT	M	M
☐ Safety	M	M
☐ Functional / Musculoskeletal	M	M
☐ Skin / Wound	M	M
☐ Cardiovascular	M	M
☑ Respiratory	M	M
☐ Gastrointestinal	M	M
☑ Genitourinary	M	M
☐ Nutrition	M	M
☐ Discharge Planning		
☐ Other		

ASSESSMENT SIGNATURE GRID

AM SHIFT ASSESSMENT
SIGNATURE Ashley Fernandez RN TIME 0730

PM SHIFT ASSESSMENT
SIGNATURE _____ TIME _____

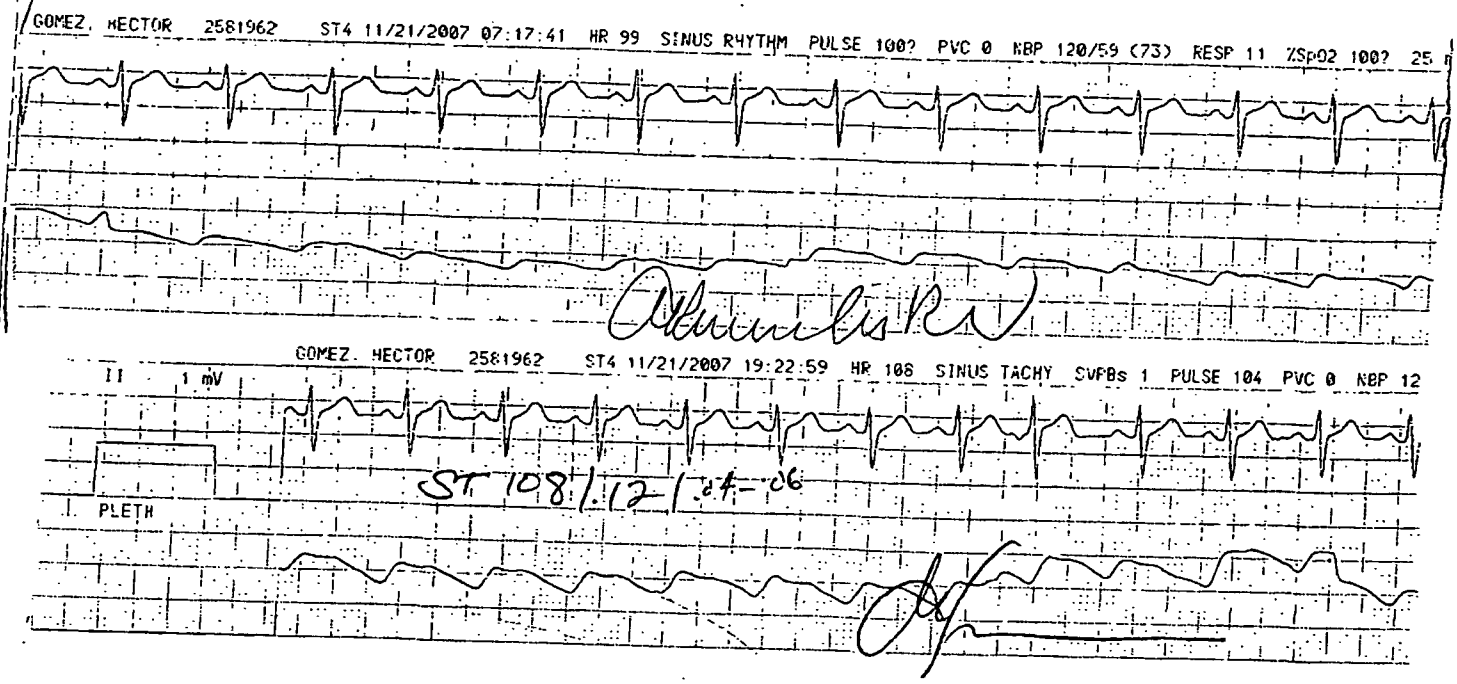
UP# 411230 rev 8/03

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page 8 of 12

GASTROINTESTINAL

☐ A ☐ P **WNL:** Normal bowel sounds. Abdomen soft, nontender. BMs of normal pattern & consistency, continent. No complaint of nausea or vomiting. Normal dentition and mucous membranes intact.

Last BM 11/14/07

Abnormal Findings

Bowel sounds
☐ A ☐ P Hyperactive
☐ A ☐ P Hypoactive
☐ A ☐ P Absent

Abdomen
☐ A ☐ P Firm ☐ A ☐ P Guarded
☐ A ☐ P Distended ☐ A ☐ P Tender
☐ A ☐ P Nausea ☐ A ☐ P Vomiting
☐ A ☐ P Girth (cm)_____
☐ A ☐ P Hernia, site_____

Bowel habits
☐ A ☐ P Incontinent
☐ A ☐ P Diarrhea

Ostomy

	Type	Location	Stoma Appearance
A			
P			

Mouth
☐ A ☐ P Poor dentition ☐ A ☐ P Stomatitis
☐ A ☐ P Lesions ☐ A ☐ P Thrush

GI tubes/drains ✓ = placement

Type	✓ / location		Suction		Drainage	
	A	P	A	P	A	P
NGT						
OGT						
Small bore feeding tube						
G-tube	Prev	LUQ ✓	F	F	F	F
J-tube						
Rectal tube/bag						

Codes:
Suction: LI = low intermittent; LC = low continuous; G = gravity; C = clamped
Drainage: GR = green; CG = coffee ground; F = feeding; B = bloody; BR = brown; CL = clear; U = undigested food

Any problems identified, implement **GastroIntestinal** section of the **POC.**

GENITOURINARY

☐ A ☐ P **WNL:** Continent with adequate output of clear yellow urine. No changes in urinary pattern or characteristics. No abnormal penile or vaginal bleeding or discharge.
☐ A ☐ P Menses

Abnormal Findings

Voiding patterns
☐ A ☐ P Incontinent ☐ A ☐ P Dysuria
☐ A ☐ P Bladder distention ☐ A ☐ P Unable to void
☐ A ☐ P Frequency/Urgency

Urine characteristics
☐ A ☐ P Oliguria ☐ A ☐ P Polyuria
☐ A ☐ P Anuria ☐ A ☐ P Cloudy
☐ A ☐ P Amber ☐ A ☐ P Hematuria
☐ A ☐ P Foul odor
☐ A ☐ P Other_____

Tubes / devices
☐ A ☐ P Condom ☐ A ☐ P Foley
☐ A ☐ P Suprapubic
☐ A ☐ P Nephrostomy ☐ R ☐ L
☐ A ☐ P Ureterostomy ☐ R ☐ L

Urinary diversion

	Type	Location	Stoma Appearance
A			
P			

Renal replacement therapy
Type: A_____ P_____

AV shunt/fistula access

	Location	Appearance	Bruit
A			
P			

Peritoneal dialysis catheter / fluid

	Location	Appearance	Drainage
A			
P			

Code: C=clear; CU=cloudy; B=brown; R=red

Reproductive
☐ A ☐ P Problematic penile or vaginal bleeding or discharge
☐ A ☐ P Concerns about sexual function
☐ A ☐ P Gravid (if yes, complete **Uterine/Fetal** section)

Any problems identified, implement **Genitourinary** section of the **POC.**

UTERINE / FETAL

(Complete for OB Patients Only)

Antepartum _____# weeks gestation
☐ A ☐ P **WNL:** Active fetal movement after 24 weeks. No or rare contractions. Intact membranes. No bleeding.
○ Document any variations from normal limits in progress notes.

Postpartum Delivery date_____
☐ A ☐ P SVD
☐ A ☐ P C/Section
☐ A ☐ P **WNL:** Fundus firm @ or below umbilicus. Small to moderate lochia. Perineum intact. Breasts soft, nontender, no nipple trauma.
○ Document any variations from normal limits in progress notes.

FUNCTIONAL / MUSCULOSKELETAL

☐ A ☐ P **WNL:** Age appropriate active ROM of all extremities with symmetry and strength. No activity restrictions. No use of musculoskeletal devices. Speech clear.

Abnormal Findings

	R Arm		L Arm		R Leg		L Leg	
	A	P	A	P	A	P	A	P
Limited ROM								
Weakness		guarded				guarded		
Contractures								
Paralysis								
Non wt bearing								

Sensation
☐ A ☐ P Tingling
☐ A ☐ P Numbness Location_____

Devices Site / Type
☐ A ☐ P SCD/foot pump BLE
☐ A ☐ P TED
☐ A ☐ P Traction
☐ A ☐ P Cast/splint
☐ A ☐ P External fixator
☐ A ☐ P Other

Speech
☐ A ☐ P Slurred ☐ A ☐ P Unable to verbalize 2° trach
☐ A ☐ P Aphasic ☐ A ☐ P Difficulty swallowing

Any problems identified, implement **Functional / Musculoskeletal** section of the **POC.**

SKIN / WOUND

☐ A ☐ P **WNL:** Skin warm, dry & intact, color appropriate to race.

Abnormal Findings

Color ☐ A ☐ P Pale
☐ A ☐ P Cyanotic
☐ A ☐ P Jaundice
Turgor ☐ A ☐ P Loose
☐ A ☐ P Tight
Temperature ☐ A ☐ P Cool
☐ A ☐ P Diaphoretic

Skin Impairments Location
☐ A ☐ P Surgical incision_____
dressing type/appearance_____
☐ A ☐ P Drain_____
☐ A ☐ P Drain_____
☐ A ☐ P Wound head laceration
dressing type/appearance sutures
☐ A ☐ P Other_____
☐ A ☐ P Other Ptosis - neuro
Wound vac™

	Location	mmHg	Suction
A			
P			

Any problems identified implement **Skin/Wound** section of the **POC.**

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 21 2007

SURGICAL INCISION / WOUND CARE

Surgical Incision #1 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Surgical Incision #2 Location _____
☐ Sutures ☐ Staples ☐ Steri strips
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
☐ Bloody ☐ Odor
Surrounding skin
☐ Normal ☐ Erythema ☐ Induration
☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #1 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

Wound #2 Location _____
Type ☐ Surgical wound
☐ Leg ulcer
☐ Skin tear
☐ Pressure ulcer / Stage I II III IV (circle)
Size: Measure on admission and every Monday
Length _____ cm
Width _____ cm
Depth _____ cm
Drainage amount
☐ None ☐ Scant ☐ Small ☐ Moderate ☐ Large
Drainage type
☐ Serous ☐ Serosanguinous ☐ Purulent
Drainage odor
☐ Yes ☐ No
Wound base
☐ Red %____ ☐ Yellow %____ ☐ Black %____
Wound margins
☐ Intact ☐ Erythema ☐ Undermined _____ cm
Periwound skin
☐ Intact ☐ Macerated ☐ Erythema ☐ Other _____
Dressing change _____ Time
Dressing type _____

OBSERVATIONS AND TREATMENTS

Cough Codes: P = productive; NP = non-productive **Secretions Codes:** Cl = clear; B = bloody; F = frothy; P = purulent; Y = yellow; T = tan; Th = thick; TN = thin; W = white

Time	08	10	12	14	16	18	20					
Suction/cough / Secretions												
HOB>30 degrees unless contraindicated							30°					
A line site ✓							NA					
IV site ✓							✓					
Chest tube patent ✓							NA					
NG/OG place ✓							NA					
Mouth care												
Turn / Passive ROM												
Side Rails												
Incen. Spir./ deep breathe							x3					
Alarms on / Assessment reviewed												

UP# 411230 rev 8/03

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 21 2007

NEUROLOGIC / EENT

☐ A ☐ P **WNL:** Alert & oriented X 3. Follows commands. No sensory or motor deficits. Reflexes present. Spanish speaking
☐ A ☐ P **WNL:** Ears - Normal hearing or hearing aid. Absence of drainage.
☐ A ☐ P **WNL:** Eyes - Normal closure, absence of swelling, discoloration and drainage. No visual impairment or wears corrective lens. PERLA
☐ A ☐ P **WNL:** Fontanel soft and flat.

Abnormal Findings

☐ A ☐ P Glasgow coma scale < 15 in non-sedated state.
☐ A ☐ P Chemical paralysis/sedation

Strength 0-none 1-weak 2-strong

	RUE	LUE	RLE	LLE
A	2	2	2	2
P	2	2	2	2

Reflexes Absent
☐ A ☐ P Cough ☐ A ☐ P Gag
☐ A ☐ P Corneal

Drainage
☐ A ☐ P Otorrhea ☐ A ☐ P Rhinorrhea
☐ A ☐ P Eye
1- clear 2-cloudy 3-bloody

Drain Type:

Location:	A	P	A	P	A	P
Drainage						
Transducer Level						
Dressing						
HOB degrees						

Drain for _____

Devices
☐ A ☐ P Cervical collar Miami J
☐ A ☐ P Cervical traction
☐ A ☐ P Halo
☐ A ☐ P Tongs
☐ A ☐ P Shunt: _____
☐ A ☐ P Codman reference # _____
☐ A ☐ P Other _____

Impairments
☐ A ☐ P Hearing
☐ A ☐ P Eyes
☐ A ☐ P ~~Unable to assess~~ ERROR
Fontanel
☐ A ☐ P Full ☐ A ☐ P Bulging
☐ A ☐ P Sunken
Emotional status
☐ A ☐ P Inconsolable

● Any problems identified, implement **Neurologic / EENT** section of the POC.

CARDIOVASCULAR

☐ A ☐ P **WNL:** Normal sinus rhythm, appropriate rate for age. S1 S2. No angina or chest pain complaints. Peripheral pulses full, palpable, skin warm, dry, with color appropriate for race. Capillary refill < 3 sec. No thigh/calf tenderness. Absence of edema. Alarms on.

Abnormal Findings

Heart
☐ A ☐ P Arrhythmia STach
☐ A ☐ P Click
☐ A ☐ P S3
☐ A ☐ P Distant heart sounds
☐ A ☐ P S4
☐ A ☐ P Rub
☐ A ☐ P Capillary refill > 3 sec.

Murmur
☐ A ☐ P Faint
☐ A ☐ P Moderate
☐ A ☐ P Loud
☐ A ☐ P Absent if expected in congenital defects

TOCS Black O Bood

Skin

	Cool	Hot	Cold	Clammy	Diaphoretic
A					
P					

Edema trace +1 +2 +3 +4

	RUE	RLE	LUE	LLE	General
A	+1	+1	+1	+1	
P		Peed			

Pulses D=doppler; 0=absent; 1+=weak; 3+=bounding

	RUE	RLE	LUE	LLE	Other
A	+2	+2	+2	+2	
P	2+	2+	2+	2+	

Pacemaker / wires
☐ A ☐ P Permanent ☐ A ☐ P Transvenous
☐ A ☐ P Transcutaneous ☐ A ☐ P Epicardial
Temporary pacer mode: _____

	Rate		mA		Sensitivity	
	A	V	A	V	A	V
A						
P						

☐ A ☐ P PA catheter
☐ A ☐ P AICD

● Any problems identified, implement **Cardiovascular** section of the POC.

RESPIRATORY

☐ A ☐ P **WNL:** Spontaneous respirations, non-labored and regular breath sounds clear in all lobes. No cough. No dyspnea. Natural airway. No supplemental O_2 requirements.
☐ A ☐ P: Suction functioning
☐ A ☐ P: Ambu bag/mask present TC 14 fr

Abnormal Findings

Respirations
☐ A ☐ P Labored ☐ A ☐ P Shallow
☐ A ☐ P Irregular ☐ A ☐ P Orthopnea
☐ A ☐ P Stridor ☐ A ☐ P Pleural rub
☐ A ☐ P Accessory muscle use
☐ A ☐ P Chest excursion asymmetrical

Tracheal deviation
☐ A ☐ P Right ☐ A ☐ P Left

Breath sounds: C=crackles; R=rhonchi; W=wheeze; RB=rub; D=decreased; A=absent

	RUL	RML	RLL	LUL	LLL
A					
P	R	R	D	CTA	D

Airway O=oral; NP=nasopharyngeal; ET=ET-tube; T=tracheostomy; L=laryngectomy

	Type	Size	Stoma Appearance	ETT placement @ lip
A	T	8	Pink	
P	Shiley	8.0	Pink	

☐ A ☐ P Emergency trach supply box
☐ A ☐ P Oral airway at bedside

Chest Tubes / Drains

Drainage
S=serous; SS=serosanguinous; B=bloody; P=purulent
Air leak / SQ emphysema
P=present; A=absent

Location	Suction amt or H_2O Seal		Drainage		Air Leak		SQ emphysema	
	A	P	A	P	A	P	A	P

● Any problems identified, implement **Respiratory** section of the POC.

UP# 411230 rev 8/03

"PRGRECRD"

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Patient Name
MRN Adm:11/01/07 M:2581962

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/21/07		ortho alert follows simple commands R 2-5 toes gangrenous changes plan for amputation when wound stabilized [signature] 1830
11/21/07	1015	Speech Path Consult received & appreciated. Eval completed & full report to follow. Brief fiberop & recs: Pt able to make adequate cuff through upper airway for voicing or speaking valve placement. Rec's ① Ord NPO & TF's ② oral care ③ Consider downsizing trach to #6 cuffless as MD/PT feel appropriate. Thank you J. Crosby, MS CCC-SLP #13416

prgrecrd1

OTE 700222 Rev. 9/06

PRGRECRD

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INTERDISCIPLINARY PROGRESS NOTES

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR M:2581962

(10:30 am)

ATTENDING PHYSICIAN NOTE

Patcom: 490943644
MRN: 2581962
NAME: Hector Gomez

Date: 11/21/07
Service: ICU

The patient has been seen and examined prior to my personal service. I have reviewed the house staff documentation and a discussion of the H & P findings has been held.

History:

☐ Upon examining the patient, it is my belief that a reliable history can not be obtained due to _____
Upon personally questioning the patient. I can confirm that the following are the key history factors:

Physical Examination: Pulse: 167 BP: 79 Resp Rate: 12 T: 97.5 Input: 2080 Output: 1665

Neuro: AA, PERRL
Eyes: follows commands
ENT:
CV:
Resp: ST, 1-2/6 SEM
GI/Nutr:
GU/Renal:
MuscSkel:
Skin:
Psych:
Other:

☐ I have reviewed the results of pertinent laboratory tests as documented in the resident's note.
☐ I have reviewed the results radiographs as documented in the resident's note.
☐ I have personally reviewed pertinent X-ray examinations.
☐ I have personally reviewed the results of additional medical testing and monitor output.
☐ I have personally discussed the case with _____

Diagnoses/Problems

1.	☐New	☐Improved	☐Unchanged	☐Worsening
2.	☐New	☐Improved	☐Unchanged	☐Worsening
3.	☐New	☐Improved	☐Unchanged	☐Worsening
4.	☐New	☐Improved	☐Unchanged	☐Worsening
5.	☐New	☐Improved	☐Unchanged	☐Worsening
6.	☐New	☐Improved	☐Unchanged	☐Worsening

Management Options/Recommendations

1.
2.
3.
4.
5.
6.

Risk of complications/mortality: ☐Minimal ☐Low ☐Moderate ☐High
☐ It is critically ill/injured. I spent _____ minutes providing critical care to this patient.
Overall Condition: ☐Critical ☐Serious ☐Fair ☐Good

Signature Date 11/21/07

UMA #19100-13 revised 11/06

"PRGRECRD"

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/08

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time
11/2/07	1500

Ortho - Staff

Tracheostomy/vent support, awake & follows commands
Moves fingers/toes to command
(+) Sensation splint (R)
(+) DP pulse (2+) (B)
(R) 2-4 toes & dry gangrene PIP → distal and 5th from MTP → distal.
Skin on plantar surface healthy; dorsal surface proximal to gangrenous zone is recovering.
A/P Crush injury (R) foot & dry gangrene 2-5 toes
- Cont. to keep digits dry & prevent cellulitis/abscess.
- Plan Transmet amputation next Wed/Thurs if he remains stable.

Staff

prgrecrd1

OTE 700222 Rev. 9/08

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OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CERVICAL SPINE 2 VIEWS AP/LAT
Accession #: 5098405

MRN: 002581962
Date Exam Completed: 11/27/2007 12:05
Last Update: 11/27/2007

EXAMINATION: CERVICAL SPINE X-RAY 11/27/07 12:05:00

ACCESSION NUMBER: 5098405

INDICATION: Male sp accident of crane falling on patient while at work.

COMPARISON: Cervical spine radiograph 11/6/07

FINDINGS: Two lateral views of the cervical spine in flexion and extension, two swimmer's lateral views of the cervical spine with incomplete visualization of the upper thoracic vertebral bodies reveal inferior and posteriorly displaced fractures of the spinous processes of C7 and T1. No evidence of cervical instability from C7 and above. No prevertebral soft tissue swelling.

IMPRESSION:

1. Incomplete visualization below C7, no evidence of cervical instability.

2. Inferiorly and posteriorly displaced spinous process fractures at C7 and T1.

VOICE DICTATED BY: Dr. Daniel Zapton
I have reviewed the images and agree with the findings in this report.

History: Male sp accident of crane falling on patient while at work.

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG CERVICAL SPINE 2 VIEWS AP/LAT
Accession #: 5098405

MRN: 002581962
Date Exam Completed: 11/27/2007 12:05
Last Update: 11/27/2007

Technologist: KIM MURDAUGH
Interpreter 1: TIMOTHY ALDER
Interpreter 2: D. ZAPTON
Interpreter 3:
Date Dictated:

Transcribed by: Tech IntTalk

Proxy Signer:

Authenticating Radiologist: TIMOTHY ALDER
Date Authenticated: 11/27/2007

MUSC Medical Center
OPERATIVE NOTE
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Date of Surgery: 11/30/2007
Surgeon: Shane K. Woolf, MD
Assistant(s): Shaun L. Traub, MD

PREOPERATIVE DIAGNOSIS: Ischemic right foot (toes 2-5).

POSTOPERATIVE DIAGNOSIS: Ischemic right foot (toes 2-5).

PROCEDURES: Transmetatarsal amputation, toes 2-5, right foot.

ANESTHESIA: General.

ESTIMATED BLOOD LOSS: 25 cc.

TOURNIQUET TIME: 60 minutes at 300 mmHg.

INDICATIONS FOR PROCEDURE: Mr. Gomez sustained a crush injury on an industrial site approximately a month ago. He sustained a closed head injury as well as crush injury to the right forefoot. He had multiple phalangeal fractures, some of which were opened. These were debrided and pinned along with nailbed repairs. Subsequently, his foot, secondary to the crush trauma, became ischemic. He failed all measures to improve perfusion to the forefoot. He developed dry gangrene which remained stable and a local adjacent soft tissue stabilized and declared healthy, while the toes themselves necrosed. He is stable medically for transmetatarsal amputation and wound closure.

Consent via an interpreter on 2 separate occasions. His situation was discussed with him. He expressed understanding. The proposed procedure involving transmetatarsal amputation of toes 2-4 with local flap coverage was discussed including risks and benefits of infection, blood loss, nerve and vessel injury, neuroma formation, painful ambulation, and need for more surgery in the future as well as risks of anesthesia. He expressed understanding and agreed to proceed.

DESCRIPTION OF PROCEDURE: Following consent and identification of the correct operative site, he was taken to the operating room and placed supine on the operating table. He was placed under anesthesia successfully and prophylactic antibiotics were administered. A well-padded tourniquet was placed on his right upper thigh. The right lower extremity was cleansed with chlorhexidine and prepped and draped as a sterile field with Betadine. The limb was exsanguinated with gravity and the tourniquet inflated.

An oblique fishmouth incision was made along the margin of the healthy skin on the dorsal and plantar aspect of his foot. Dissection was carried down to the extensor tendons which were transected proximal to the incision line. The digital neurovascular bundles were individually identified and retracted proximally and then transected with electrocautery. The metatarsophalangeal joint was identified and amputation continued sharply through this plane. On the volar surface, dissection was carried down to the flexor tendons which were drawn into the wound and cut proximal to the incision line as well. The distal stump of tissue was completely removed at that point. The great toe was left undisturbed as the skin of the webspace was healthy and there was no evidence of permanent ischemic damage. Periosteum of toes 2-5 was elevated proximal to the metatarsal head, exposing the

metatarsal shaft. Toes 3, 4, and 5, were then transected transversely with a bone cutter, and a rongeur and rasp were used to smooth the cut ends to eliminate any sharp bony prominences. The second metatarsal head was contoured gently with a rongeur to minimize the bony prominence, but would permit skin coverage and thus was not transected more proximally. The wound was irrigated copiously with saline. Remaining vessels were coagulated with the Bovie. The periosteum of toes 3, 4, and 5 were then closed over the exposed bone with 2-0 Vicryl suture to provide additional padding and minimize bleeding. The plantar fascial flap was repaired back to dorsal subcutaneous tissue with several 0 PDS sutures. The large skin flaps were then repaired without tension using 3-0 nylon in a vertical mattress configuration.

The tourniquet was deflated and there was satisfactory hemostasis. Sterile dressings including fluff gauze were applied to the foot, and he was placed in a postoperative shoe. He was awakened from general anesthesia and transferred to the recovery room in stable condition. He tolerated surgery without apparent complications. All sponge and needle counts reported as correct at the end of the case.

I was present throughout the procedure.

Dictated by: Shane K. Woolf, MD

Shane K. Woolf, MD
Surgeon

498556 / 31185 /
JOB: 372939
DD: 11/30/07 02:25 PM
DT: 12/04/07 10:00 AM

Additional CC:_____

DOCID: 18232498556

Electronically signed by SHANE WOOLF, on 12-17-2007 at 05:02:57 PM

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

Medical University of South Carolina
Charleston, SC
843-792-2123
Radiology Report

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG FOOT,COMP/MIN 3 VIEWS
Accession #: 5102660

MRN: 002581962
Date Exam Completed: 11/30/2007 12:10
Last Update: 11/30/2007

EXAMINATION: FOOT XRAY 11/30/07 12:10:00

ACCESSION NUMBER: 5102660

INDICATION: CHECK SCREW PLACEMENT RIGHT FOOT

COMPARISON: 11/04/07

FINDINGS: AP, lateral, and oblique views of the right foot demonstrate interval removal of the multiple K wires seen on the prior examination. The previously described fractures within the foot remain present without evidence of healing. There appears to be no operative correction of these fractures.

IMPRESSION:
Removal of prior K wires without evidence of operative fixation of multiple fractures within the right foot.

VOICE DICTATED BY: Dr. RICHARD COURSEY
I have reviewed the images and agree with the findings in this report.

History: CHECK SCREW PLACEMENT RIGHT FOOT

Technologist: CHRISTOPHER SIMMONS
Interpreter 1: WILLIAM CONWAY

Proxy Signer:

This document should not be filed in the paper medical record and should be confidentially destroyed when it is no longer needed.
Printed: 01/07/2008 10:37 AM
Printed by: LINCOLN, COURTNEY

Patient: GOMEZ-FRAGOSO, HECTOR
Procedure: DIAG FOOT,COMP/MIN 3 VIEWS
Accession #: 5102660

MRN: 002581962
Date Exam Completed: 11/30/2007 12:10
Last Update: 11/30/2007

Interpreter 2: RICHARD COURSEY
Interpreter 3:
Date Dictated:

Authenticating Radiologist: WILLIAM CONWAY
Date Authenticated: 11/30/2007

Transcribed by: Tech IntTalk

MUSC Medical Center
HOSPITAL DISCHARGE SUMMARY
Patient Name: GOMEZ, HECTOR
MRN: 002581962
Patcom: 490943644
Admitted: 11/01/2007
Discharged: 12/01/2007
Service: Trauma Surgery
Attending: CHRISTIAN T MINSHALL, MD

Referring:

ADMITTING DIAGNOSES:
1. Status post skull fracture.
2. Open complex scalp wound with epidural and subdural hematoma.
3. Bilateral frontal contusions.

HISTORY OF PRESENT ILLNESS: This is a 27-year-old Hispanic male who was hit in the head with part of a construction crane with positive loss of consciousness at the scene, significant blood loss, positive emesis at scene. He was intubated by EMS. This occurred in Marion County after an elevated crane fell and hit him. The patient was attempted to be intubated by Marion County which was unsuccessful. Then, Carolina Lifecare was able to intubate.

REVIEW OF SYSTEMS: Per HPI.

PAST MEDICAL HISTORY: Unknown.

PAST SURGICAL HISTORY: Unknown.

SOCIAL HISTORY: Questionable use of ETOH.

DISCHARGE PHYSICAL EXAMINATION: Vital signs: Temperature 99.3, heart rate 114, respiratory rate 19, blood pressure 118/81, saturating 99% on room air. Neurologic: Patient alert and oriented. Cardiovascular: Regular rate and rhythm. No murmurs, gallops, or rubs. Lung sounds clear to auscultation bilaterally. Abdomen: Positive bowel sounds, nontender, nondistended. Trauma: PEG tube in place. Extremities: Right foot in dressing, clean, dry, and intact. Moves knee and ankle joints.

DIAGNOSTIC TESTS: CT of the abdomen on 11/01/2007 showed a right adrenal hemorrhage, bilateral L1 and L2 and right L3 transverse process fractures and multiple posterior rib fractures.

CT pelvis on 11/01 showed a high density structure in the rectum of uncertain significance.

CT of the head on 11/01/2007 showed a comminuted fracture with small extraocciptoparietal hematoma at the midline at the vertex, worrisome for a small epidural hematoma.

CT of the chest with contrast on 11/01/2007 showed bilateral lung contusions and/or aspiration. Right clavicle fracture and C7 and T1 spinous process fractures.

Patient has had multiple CTs of the head and chest x-rays.

CONSULTS SERVICE:
1. Neurosurgery.
2. Orthopedics.

HOSPITAL COURSE: The patient had a protracted hospital stay. Patient was admitted initially through the trauma bay via trauma protocol and then taken to the STICU for medical management.

Neurology: Patient was managed by neurosurgery for his subdural and epidural hematomas. Patient was also managed for multiple spinous process fractures. Patient has subsequently recovered function. He was ambulating without any difficulties, moving all extremities. Patient alert and oriented x3.

Cardiovascular: Patient remained hemodynamically stable. No acute issues.

Pulmonary: Patient initially intubated en route from Marion County by the air medical services. Patient was subsequently transferred to STICU on the ventilator service. Patient had failure to wean off the ventilator and subsequently had a tracheostomy performed while in the hospital. Subsequently, patient had tracheostomy removed.

Gastrointestinal: A PEG tube was placed for nutritional concerns. Patient tolerated tube feeds throughout his stay. Subsequently, after patient was transferred to floor, tube feeds were held and patient was started on p.o. intake. Patient was tolerating p.o. without any problems. PEG tube remained intact at time of discharge to be pulled out at his appointment with trauma surgery.

Musculoskeletal: Patient with multiple fractures that were initially evaluated and treated by orthopedics. The day prior to discharge, the patient was taken to the operating room by orthopedics to have his 2nd through 5th metatarsals amputated. Patient had a full weightbearing status at time of discharge. Subsequently, physical therapy recommendations no further out of hospital physical therapy needed.

DISCHARGE DIAGNOSIS(ES):
1. Subdural and epidural hematomas.
2. Bilateral frontal contusions.
3. Respiratory failure.
4. Hypotension that was treated with intravenous fluid.
5. Scalp laceration with large complex, status post repair.
6. C7 and T1 spinous process fractures.
7. Right rib fractures which included 7, 8, 9, 10.
8. Bilateral transverse process fractures of L1 and L2, right L3.
9. Right big toe fracture.
10. Right fifth toe fracture.
11. Fracture of skull, midline to sagittal through frontal and parietal.
12. Placement of percutaneous endoscopic gastrostomy.
13. Tracheostomy.
14. Status post amputation of 2nd through 5th toes.

DISCHARGE MEDICATIONS: Patient will go home on oxycodone. He will take 1-2 tabs p.o. q.4-6 h. p.r.n. pain.

DISCHARGE PLANS: Patient will follow up with orthopedic clinic at McClennan-Banks on Wednesday in 2 weeks. Patient will also follow up with trauma clinic on Friday in 2 weeks.

DISCHARGE INSTRUCTIONS: Patient is to call for temperature greater than 101.5, pain not controlled with medicine, redness around or drainage from wound. Additionally, patient is to keep wound dry until seen by orthopedics. Activity as tolerated. Diet as tolerated.

Dictated by: Daniel Schwerin, MD

_____
Daniel Schwerin, MD

_____
CHRISTIAN T MINSHALL, MD
Attending

513512 / 30028 /
JOB: 373087
DD: 12/01/07 01:36 PM
DT: 12/04/07 10:26 PM

Additional CC:_____

DOCID: 18233513512

Edited By DANIEL SCHWERIN MD on 12-19-2007 at 08:27:06 AM

* P R G R E C R D *

MUSC
THERAPEUTIC SERVICES
Discovering. Understanding. Healing.

Medical University Hospital Authority
Rehab Services
Charting Report

NAME: GOMEZ, HECTOR **PAT** 490943644 **MRN** 002581962

Date/Time: 11/23/2007 1:17:00PM Patient Room/Bed at Time of Encounter: 006W:D657/A

Orders Completed:			
EVAL30	Evaluation: 30 minutes; Untimed use only one per e	Number Performed:	1
THERA	Therapeutic Activity: transfers, closed chain and	Number Performed:	1

Physical Therapy Initial Evaluation

Date/Time of Evaluation: 11/23/07 0930
Physician Service: MINSHALL, CHRISTIAN
Funding: FX

Initial Assessment:
Diagnosis: crane accident
History of Present Illness/Mechanism of Injury: HECTOR GOMEZ is a 56 year old M who presents with with crane accident at work. Admitted 11/1 after crane fell and landed on pt. Pt sustained skull fracture, B frontal contusion, R great toe distal phalanx fracture, R 2-5 toes proximal phalanx fracture (R 4 and 5 open), C7-T1 spinous process fractures, R 7-10 rib fractures, B L1-L3 transverse process fractures, R L3 transverse process fractures, R clavicle fx. S/p I and D and pinning of R toes 11/2. Trach placed 11/16. Sustained post traumatic vasospasm of R foot-pt now with gangrenous toes and awaiting possible TMA.
Past Medical History (medical complications): none

Home Environment: unknown-pt reports living in Marion County
Prior Level of Function/Occupation: unknown

Subjective: pt Spanish speaking only with minimal English. No translator available
Pain (average pain intensity over the last 24 hours (0=no pain 10=E.R.)):pt shakes head no to pain when questioned in Spanish
Patient Goals: none stated

Objective:
Treatment Location: Patient seen bedside.
Mental Status: alert, following all commands with cues/gestures/Spanish commands as able, unable to accurately assess orientation
Barriers to Learning/Goals: Language Cognitive?
Special Conditions: trach, IV, foley, SCD's, PEG, Miami J collar, B UE restraints
Range of Motion:
* Upper Extremities: WFL
* Lower Extremities: WFL
Strength:
* Upper Extremities: WFL except: R shldr NT due to clavicle fracture
* Lower Extremities: WFL except: R ankle NT formally due to gangrene but pt moving WFL
Endurance: Fair - Tolerates 5 to 15 minutes of an uninterrupted exercise bout.
Sensation: Not Tested Location: formally due to language but pt shakes head that he can feel light touch in all 4 extremities-needs further assessment of R foot/toes

Balance: Sitting (Motor Assessment Scale for Sitting Balance 0-6) is 2 initially but progressed quickly to 3 as dizziness

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Rehab Charting Report Continued

NAME: GOMEZ, HECTOR **PAT** 490943644 **MRN** 002581962

subsided
Muscle Tone: no abnormal tone noted
Level of Function at Start of Care (FUNCTIONAL LIMITATIONS) :
- Bed mobility:
  -Rolling: Right: Minimum Assistance
  -Scooting: Minimum Assist
  -Supine to Sit: Minimum Assist
  -Sit to Supine: Minimum Assist
- Transfers
  -Sit to Stand: Patient is moderate assist (x 3 reps) pt able to maintain NWB R LE after demo given-stood with min assist static stand
  -Bed to Chair: Not tested as pt declined OOB/ambulation
- Ambulation: NT
- Stairs: NT
-Wheelchair Propulsion: Not Tested

Treatment: Total Treatment Time: 30 minutes. Total Treatment Time Timed Codes: 15 Evaluation, Transfer Training Bed Mobility Training. :
Patient/Family Education: Patient was instructed in P.T. Role Weight Bearing Precautions,
Response to Education: Needs Reinforcement.
Equipment Owned: unknown
Equipment Needed: ongoing assessment

Assessment:

Pt presents s/p crane accident with multiple fractures, CHI and now awaiting possible TMA for R foot gangrene. Moving well despite language barrier. Good understanding of NWB status but needs reinforcement in Spanish to promote compliance. If TMA performed, will need resume PT order when pt medically stable and appropriate. Will cont to assess for needs
Patient's Response to Treatment: dizziness with sitting EOB
Impairments (problem list): decreased mobility
decreased ambulation
R foot gangrene NWB
Prognosis based on patients medical history, response to education, home exercise performance, and response to treatment: good
Plan of Treatment/Functional Goals:
Short Term Goals as discussed with patient and/or family to be met by 11/30/2007
* Patient to perform rolling with Modified Independence for position in bed.
* Patient to perform supine to sit with Modified Independence for getting in and out of bed.
* Patient to perform sit to stand with Modified Independence to come to stand for ambulation..
* Patient to ambulate >30 feet with Modified Independence with least restrictive assistive device for household ambulation.

Will update stair goal as home setting determined with translator

Outcome Goals (Long Term as discussed with patient and/or family) to be met in 3 months.
* Patient will demonstrate independence with all transfers.
* Patient will ambulate >2500 feet Independently with least restrictive assistive device.
In order to achieve the maximum level of independence with all personal, household, and community activities.

Plan:

Continue PT daily.
Treatment Specifics: transfer training gait training education balance training therepeutic exercise wheelchair mobility training to achieve maximum independence and safety.



Rehab Charting Report Continued

NAME: GOMEZ, HECTOR	PAT 490943644	MRN 002581962

*FUNCTIONAL ACTIVITY SCALE
Total Assist: patient expends < 25% of effort
Maximum Assist: patient expends >25% and <50% of effort.
Moderate Assist: patient expends >50% but <75% of effort.
Minimal Assist: patient expends >75% of effort.
Supervision: patient requires only verbal cues or coaxing.
Modified Independence: patient requires assistive device, extra time, or there is a safety risk.
Independent:patient is completely independent.

*MOTOR ASSESSMENT SCALE FOR BALANCED SITTING:
1. sits only with support
2. sits unsupported for 10 seconds
3. sits unsupported with weight well forward and evenly distributed
4. sits unsupported, turns head and trunk to look behind
5. sits unsupported, reaches forward to touch floor and returns to starting position
6. sits unsupported, reaches sideways to touch floor and returns to upright

*TINETTI GAIT AND BALANCE:
High Fall Risk: score of less than or equal to 19 out of 28 points
Moderate Fall Risk:score of 20-24 out of 28 points
Low Fall Risk: score greater than or equal to 25/28 points
Electronically Signed by: Paige Thomas, MSRPT

If you received this report in error, please notify the MUSC Compliance Office immediately at (843) 792-4037 or 1-800-296-0269. Thank you.

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PRGRECRD

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3 Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR M:2581962
Patient Nam Adm:11/01/07
MRN

STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/23/07	0950	PT - Consult received & eval completed. Thanks for this referral. Paige Thomas, PT MSK 1937
11/23/07	1205	OT S: "Agua" - asking for water O: Pt's BS low 30 min. Pt. awake, alert follows simple commands makes attempts to verbalize. Indicated that he wanted water. Adl: Pt was able to swab mouth using toothette. Min (A) to don gown due to (R) shoulder pain. Mobility: supine → sit c ~~S~~ min (A) sit → stand c mod (A) c weight placed on (L) foot for SPT in to chair. Pt. stood 3 times, eventually ↑ to min (A) c wk on (L), ~~Φ~~ weight in (R). Upon arrival of OT - (B) wrist restraints on but not secured. Pt is bed dishevelled + IV out - nursing notified. Pt remained seated in straight back chair c CNA present to ~~S~~ condom cath. Nursing instructed to call lift team if needed to (A) pt back to bed. Pain: Pt indicated pain in (R) shoulder - did not rate. A: Pt c fairly good transfers following commands Cont. →

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INTERDISCIPLINARY PROGRESS NOTES

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GOMEZ
Patient Name HECTOR
MRN Adm:11/01/07 M:2581962
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Date	Time	
11/23	1265	OT
P: Cont Der ~~PO~~ error & POC — Joan Ensor 12338

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Date	Time	
		Trauma
11/24/07		S: Acute events overnight: still has lots of secretions O: ~~98.4~~ 99 98° 82 116/74 18 97% on @ 50% I: 840(840) : 600) CTA(B) O: 1.2 all urine RRR, A/P: AD #24 c CHF c skull fracture - attns plans for toe amputation of (R) foot next week - pain management - full diet - change to 6.0 ~~cuffless~~ cuffed Mary Hoff, NP/C
11/24/07		Orthop: Alert and Follow commands. conversing and makes sense mentally much improved @ 2-5 toes gangenous changes. plan for toe amputaten next week 15-03

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
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Version Date: 9/08

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MRN _____
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USE: 0.5mg Not: .5 mg

Date	Time	
11/24/07	135 pm	P.T. 31 min 12 min gait training, 15 min therap. Act. Hand cords S: when will they take this out? (re: trach) O: Pt seen bed on (all. Awake in bed. On 50% O2 via trach collar @ 10L. Transferred to Ventimask. Pain 8-9/10 in upper back. Pt declined meds. Supine → sit c minimal (A). O2 sats 91% @ rest. Sit → stand c min (A). Reinforced use of WBS R LE. Pt c great difficulty c (R) foot in contact c floor & knee in stretch to use (R) heel WB only. Pt amb 50' x 1 c FWW x (1) heel WB x min (A), c (A) for IV pole, O2, etc. O2 sats 4'd 97% duke gait. Seated therex: hip flex, knee ext, APs x 5 reps. Sit → supine & up in bed c S. Pain 0/10 p session. Pt c numerous Qs re: when trach removed. Brother + 2 friends present. A: Pt c good motivation, but difficulty adhering to WBS R LE. P: Cont to PT 4x/wk to T (E) c transfers + gait until DC, and then as per TMA on R LE. On RR PT MHS 12077

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"PRGRECRD"

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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Date	Time	
11/25/07	1450	PT S: Denies pain. Agreeable to PT. Per Kristi, RN, pt has gotten self into & OOB this am (I). She also reports that he removed his C-collar & decannulated himself this am. O: Pt seen BS 6w x 25 minutes total treatment time & timed coded minutes. Sup→ sit MI. Sit↔ Stand (S) c FWW. Amb 50' c FWW & (S) on 2L O_2 via NC cannula c LOB x 2 2° to reported dizziness, Pt needing verbal & tachile cues to remain NWB on (R) forefoot. Returned to supine min (A) & left c call bell in reach & Kristi, RN aware. A: Pt has difficulty maintaining NWB (R) LE & is somewhat impulsive c transfers & initial ambulation. Anticipate return to OR tomorrow for (R) TMA. Will resume PT c new post-op orders. E. Sweet, PT 11378

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Date	Time	
11/25/07	0700	Trauma
		S NAE Trach downsized to 6 cuffed
		O 99° 95⁴ 81 116/67 16 93% O2
		I 1650 1050 TF 90 Flush S10 IV
		O 1725 UO
		RRR
		CTAB
		ABS, NT, ND
		S/p Crane VS head TCHD
		① Amb ② foot next week TCH/O
		② pain Rx
		③ full diet if pass swallow eval @bedside ?Tx - Thick liquids Only
		L Hamm

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MUSC
THERAPEUTIC SERVICES
Discovering. Understanding. Healing.

Medical University Hospital Authority
Rehab Services
Charting Report

NAME: GOMEZ, HECTOR **PAT** 490943644 **MRN** 002581962

Date/Time: 11/26/2007 3:04:00PM Patient Room/Bed at Time of Encounter: 006W:D657/A

Orders Completed: SLP255 Dysphagia Evaluation - Standard Number Performed: 1

MUSC Evelyn Trammell Institute for Voice and Swallowing
Speech Pathology Acute Care Evaluation

Patient Information

Last Name: GOMEZ
First Name: HECTOR
MRN: 002581962
Date of Birth: 01/01/1951
Date of Evaluation: 11/21/07
Patient Age: 56
Gender: M
Referring Physician: Hiott
Attending Physician: Minshall
Referring Service: Trauma
Onset of Symptoms: 11/01/07
Initiation of Treatment: 11/21/07
Review of Treatment Plan: 11/26/07
Insurance: Self Pay
Provider Number: 420004
Primary Diagnosis: TBI
Treatment Diagnosis: 787.22 Dysphagia oropharyngeal phase 784.41 Aphonia 784.60 Symbolic Dysfunction (unspecified)

Pain Assessment: Patient reports pain (unspecified), nrsg aware
Ambulatory Status: Bed rest
Barriers to Learning: Language, Cognition
Precautions: tracheostomy, restraints, NPO, pulse ox, peg tube, IV, Sequential Compression Devices
Nutritional Screening: currently using supplemental feeding techniques (g tube feeding)

Date of Service: 11/26/07

History of present illness: A 27-year-old Hispanic male who was working at a construction site as per report, the counterweight of the crane fell on his head. He has a left scalp laceration, intubated.
As per report, he was combative at the scene and had some vomiting. His wound was cleaned and sutured by the trauma service. Among other injuries, he has right big toe fracture, right fifth toe fracture, right clavicle fracture.

* P R G R E C R D *

Rehab Charting Report Continued

NAME: GOMEZ, HECTOR	PAT 490943644	MRN 002581962

11/02/2007
1. Irrigation and debridement of open fracture of phalanges (skin to bone).
2. Closed reduction and percutaneous pinning of hallux second, third, and fifth toe proximal phalanx fractures
3. Nailbed repair fourth and fifth toes

11/15/2007 - Placement of percutaneous endoscopic gastrostomy tube.

Patient was intubated on 11/1. Intubation was: emergent. Patient was extubated on 11/13, however required re-intubation that night. Trached 11/17. The patient was intubated for a total of 16 days.

Allergies: NKDA

Respiratory Status: trach capped, room air

Current Diet: NPO, PEG (orders recently written for regular diet)

Barriers to Learning: cognitive linguistic deficits, aphonia secondary to tracheostomy tube, English is not the patient's primary language

The patient was seen for a bedside swallow evaluation. Pain Scale: denied pain.

PROCEDURE: CLINICAL EVALUATION OF SPEECH/LANGUAGE/COGNITION (CPT 92506)
The patient was: awake and alert and verbally communicating

Oriented to: person and hospital, not city

Attention: WFL

Vision: Appears to be WFL.

Hearing: Appears to be WFL.

Commands: Patient is able to follow 1 step commands.

Speech was judged as follows:
Word: 100% intelligible Phrase: 100% intelligible Sentence: 100% intelligible Conversational Speech: n/a

Oral Motor: Structure and function were assessed revealing the following:

Dentition: adequate

Labial: adequate retraction and protrusion

Lingual: adequate protrusion and lateralization

Sensation is: intact

Oral Care: adequate

Voice: Voice evaluated utilizing GRBAS scale for the formalized perceptual evaluation of voice. Patient's voice was judged as follows:

* P R G R E C R D *

Rehab Charting Report Continued

NAME: GOMEZ, HECTOR	PAT 490943644	MRN 002581962

Grade = 1 /3
Roughness = 0 /3
Breathy = 0 /3
Aesthenic = 0 /3
Strain = 0 /3
Overall = 1 /15, whereby normal = 0/15.

PROCEDURE: CLINICAL EVALUATION OF SWALLOWING FUNCTION (CPT 92610):
The patient was positioned upright in bed and presented with: thin liquids, nectar thick liquids, and solid consistency (corn, chicken, broccoli, and corn bread from lunch tray).

The patient presented with prolonged mastication likely secondary to cervical collar in place restricting jaw movement. Coughing was noted following sips of thin liquids 4/5 trials. Appeared to tolerate sips of nectar thick liquids and solids without s/s of aspiration.

IMPRESSIONS:
The patient presents with: dysphagia c/b prolonged mastication of solids likely 2° cervical collar and s/s of aspiration with thin liquids.

PLAN/RECOMMENDATIONS:
1. Soft mechanical diet with nectar thick liquids.
2. Follow Swallow Guidelines, including:
- Sit upright at 90 degrees for all po intake
- Contact Speech Pathology if the patient coughs, strangles, or has difficulty breathing during PO intake
3. Nutrition to wean TF's as appropriate.
4. Consider decannulation if Pts tolerates capping trials x24 hrs without difficulty.
5. SLP to f/u for diet tolerance and upgrade as appropriate.

Long Term Goals:
1-The patient will tolerate the least restrictive diet with a safe/efficient swallow to maintain adequate nutrition and hydration.

Short-term Goals:
1- Educate patient and caregivers, re: results of this evaluation and recommendations with verbalized/demonstrated understanding.
2- Educate patient and caregivers, re: Swallow Guidelines with verbalized/demonstrated understanding.

The patient and nursing were educated, re: the results of this evaluation and the above recommendations.

The results of this evaluation and the above recommendations were communicated to Dr. Hiott via the simon paging system.

Thank you for this consult and the opportunity to care for this patient. Should you have any questions or need any additional information, please do not hesitate to page me on Simon beeper number 12616. Thank you.

Electronically Signed by: AUDRA CONDON, MSR, CCC-SLP

* P R G R E C R D *

Rehab Charting Report Continued

NAME: GOMEZ, HECTOR	PAT 490943644	MRN 002581962

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
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Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
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Date	Time	
		Trauma
11/26/07		s: Ø acute events
		o: 98% 97% RA 110/75 HR 95% on 2L NC
		I: 1.5 (660 PO)
		O: 500 + 2x urine; stool x1
		CTA (I)
		RRR
		soft NT, ND
		A/P: HO #26 c CHI, lac scalp lac, (R) clavicle fx, C3-T1 SP fracture
		- discuss c-spine with neurosurgery
		- speech consult
		- date of orthopedic surgery f/u
		Mary Hiott, 13469
11/26/07		Speech Path
		Re-consult received & appreciated (today). Full report to follow. Rec → (1) Soft mechanical diet c nectar thick liquids. (2) Will f/u for tolerance. Thank you — A. Conder, MSP, CCC-SLP #12476

prgrecrd1

OTE 700222 Rev. 9/06

"PRGRECRD"

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

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Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/26/07	1423	OT S: Pt reports walking c therapist in hall earlier O: Pt was seen BS & W briefly. Pt was sitting upright in bed eating lunch Trach capped. Pt conversing c therapist. MS: Pt oriented to time, place, situation - self following commands. ADL's: Pt feeds self independently - needs (A) to mix drinks c Thickit 2° pt. unable to handle the liquids. Pt. did not wish to get into a chair 2° being up earlier. Pain' c/o discomfort @ neck - did not rate Pt remained in bed eating. Call bell in reach A: Pt more conversive More aware/ alert. P: Cont per POC Jose Gomez O.OTR 12538

prgrecrd1

OTE 700222 Rev. 9/06

PRGRECRD

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

Patient Name _____
MRN _____
STAMP PLATE AREA

Prohibited abbreviations:

These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/26/07	am	P.T.
	2:10	S: c/o pain in neck: 8/10
		O: Pt. seen bedside x 30 total timed code & 84 min. Interpreter present
		Therex: 10 reps BLE Therex
		Transfers: supine → sit (I); sit → stand (S)
		Gait: 50' NWB (VC's required) c St. walker
		O2 sats ~ 90-90% on RA
		In chair @ RI. Call bell in hand
		A: Progressing mobility skills. Requires VC's for NWB
		P: Cont daily Tx in the for stairs
		K. Twickett, PT 12839
11/27/07		Ortho
	620 AM	Pt progressing c PT/OT - ambulated 50' yesterday
		Pt awake & alert, follows commands
		Rt 2-5th toes black, demarcations unchanged
		A/P: Rt 2-5th toe crush injury, now gangrene
		- will need amputation, will contact 1° team if able to go to OR this week.
		15668

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HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
Version Date: 9/06

Patient Name Gomez
MRN
STAMP PLATE AREA

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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
		Trauma
11/27/07		S: Ø acute events overnight
		O: 98.6 98² 74 120/77 16 94% on 2L
		I: 1.2 (940 PO)
		O: 1.3 (stool x1)
		CTA(B)
		RRR
		soft NT, ND
		A/P: HD#27 CHI, (R) clavicle frx
		- remove trach today
		- full diet
		- pain control
		- awaiting toe amputation Mary Hiott, 15469 Anderson 11495
11/28		Ortho
		OR in AM for transmetatarsal amputation
		15228

prgrecrd1

OTE 700222 Rev. 9/06

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INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3

Version Date: 9/06

P:490943644 DOB:01/01/1951
Patient Name GOMEZ HECTOR
MRN Adm:11/01/07 M:2581962

STAMP PLATE AREA

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/27		Nutrition: Diet advanced to regular & thick liquids per Speech therapy. Has eaten 50-100% meals so far. Pt to be NPO @ midnight for transmetatarsal amputation. Bm x 1 No labs since 11/22 Still receiving Prostat BID. TFs stopped. Plan: 1) Continue to monitor po intake. If po intake declines, will send supplements 2) Will continue & Prostat BID given that pt is going to OR tomorrow. 12255 Emily Chapman, RD, CNSD
11/27/07 to 11/28/07		Nurse Case Manager Note: Case discussed during rounds. F/U of workers Comp NCM - who referred me to adjustor Scott Lacey 800-605-7366 Ext 9818 in Ref. to coverage - Pt not receiving workers Comp benefits at this time. Information was communicated to Nancy Grant, UR & Terri Nedley MSW. In preparation of D/C standard walker was ordered from Apria DME / HHSPT via Amedysis HHS - Information placed in HARP via CHG nurse. - [illegible]

prgrecrd1

OTE 700222 Rev. 9/06

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HECTOR
Adm:11/01/07 M:2581962

INTERDISCIPLINARY PROGRESS NOTES

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Version: 3
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Patient Name _____
MRN _____
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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/9/07	0800	Orthop AFVSS. No complaints. Gangranous changes to (R) 2-5 toes. No signs of infection Plan: amputation to (R) 2-5 toes today by orthop. 15-035

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P:490943644 DOB:01/01/1951 L M
Patient Name GOMEZ HECTOR
MRN Adm:11/01/07 M:2581962

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mcg, µg or ug	U or u	IU	
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Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/28/07		Trauma S: Ø acute events. Ø problems since trachea removed. O: 98³ 97⁹ 66 "/15 18 98% on 2L I: 2L U.8 PO O: 450 + 2x urine CTA(B) RRR soft NT ND A/P: HD #28 s/p CHI, skull fx, cerebral bleeds. - C-spine to be cleared by neurosurgery - To OR this week with ortho - Today - continue regular diet Mary Hiott, 15469
11/30/07 10³⁵		Speech Path Pt currently NPO for OR today. Regular diet & nectar thick liquids. Decannulated 11/27. Nrsg reports cont. & cough & thin liquids. Rec → ① Cont current PO ② Will f/u for diet upgrade. Thank you — J. Condon, MSN, CCC-SLP #12616

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Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/28/07	1090	OT OR planned today for (R) 2-5 toes today. Will hold for until after surgery - Please write resume OT ordered. Thanks Jaime Gomez OTR 12336
11/28/07		Attn - Staff
	1130 AM	No changes. Toes 2-5 remain c dry gangrene, no evidence of infxn. Skin compromised to bases of phalanges 2-4 and to mid-metatarsal #5. Plan transmetatarsal amputation of (R) toes 2-5 today, poss. disarticulation of MTP joints if soft tissue coverage permitted as s/o evidence of infxn. Discussed c pt via translator. Jaime
11/28/07	1500	Nsurg: Pt seen c cg, I, pt for WI. Reports flux ex trays 5 intact bilat and patient denies medium VTP on both on full ROM. OK to be called. No follow up necessary Heather 11.28.07

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Patient Name P:490943644 DOB:01/01/1951 L M
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HECTOR
MRN M:2581962
Adm:11/01/07

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Do not write a whole number with a trailing zero.
USE: 5 mg NOT: .5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/29		Ortho - pt was scheduled for surgery, but received water at 12:00 and then on emergency surgery came in we will reschedule as soon as possible for: (R) transmetatarsal amputation 15228
11/29/07		Trauma S: ϕ acute events O: 98 96 94 126/55 16 92% RA I: 1.6 (680 PO) O: 2.3 CTA (R), RRR, soft NT, ND A/P: HD# 28 s/p CHI, skull fx, gangrenous toes - Possible DC home if ortho ϕ to take pt to OR until next week - understand emergency amputation mentioned in above note - continue regular diet Mary Hiatt, 11/29/07

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qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
11/29/07		P.T.
	11:15	Pt. has met STG's for PT & is safe to DC home c Fwu. K. Tuckett, PT DPT
11/29/07		Speech Path:
	1140	O: Swallow: Pt seen DOB @ 90°. Alert/ cooperative. Assessed thin liquids via straw sips then via small cup sip → pt. c delayed overt coughing p thins by straw sip. Voice quality ↓s p thins by small cup sip. Checked clearance of nectar thick liquids by normal cup sips → No overt evidence of laryngeal penetration/aspiration. A: Continued s/s of aspiration of thin liquids. Trained pt to finger occlude trach stoma dressing during swallow + cough. P: continue on regular consistency c nectar thick liquids by small cup sips. Continue tx per POC. Val Evans MA CCC SLP 11976

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P:490943644 DOB:01/01/1951 L N
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Adm:11/01/07 M:2581962
Patient Na
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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
		Trauma Surg
11/30	5:00	S: Ø acute events
		O: Vitals: 98⁵. 98⁵. 91. 190/82 · 20 · 95% RA I: 600 80 / O: 1700 urine Stool x1
		CV: RRR no MRG Lungs: CTAB Abd: BS, NT, ND
		Neuro: Grossly intact
		Ext (R) toe necrotic
		A: 29 yo HM s/p head injury c clean c-spine.
		P: 1. To OR c ortho for TMA.
		2. From trauma point of view, OK home after surg
		Jamie PAS Hall + agree c above — Lindsey Hall, PA-S 18178
11/20/7		RES - Staff
12 Pm		No changes. Plan transmetatarsal amputation today pending OR avail. Plan hard soled shoe postop c WBAT D/C c ortho c PT.

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Adm:11/01/07 M:2581962

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mcg, µg or ug	U or u	IU	
qd / QD	qod / QOD	MS / MSO_4	$MgSO_4$

Drug names will not be abbreviated (e.g. AZT, HCTZ, NEO)
Do not write a whole number with a trailing zero.
USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

Date	Time	
~~12/1/07~~ 11/30/07		ortho - PO Note:
		Complains pain in (R) foot.
		99.3. 114. 19. 118/81. 99% RA. Good UOP, 1000 cc
		Alert / oriented.
		(R) foot in dressing c/d/I, moves knee and ankle joints
		A/P. POD #1 Transmetatarsal amputation 2-5th toes (Right foot)
		doing well
		- continue current care
		- Pt may be D/C home
		- WBAT (R) foot
		- Flu & Mc-Bates in 2 weeks
		[illegible] 1030
12/1/07	1150	PT
		Re-consult received s/p (R) 2nd-5th toe amputation 11/30/07. New eval & full report to follow. E. Sewell, PT 11378
12/1/07	1225	PT
		Pt is safe for D/C home c FNW & family support. No further PT needs at this time. E. Sewell, PT 11378
		Addendum: Family requesting to speak to MD re: discharge plan. Notified Krista, RN, who paged trauma team. Emily Sewell, PT 11378

prgrecrd1

OTE 700222 Rev. 9/06

MRN: 2581962 Visit: 490943644 DocType: LABREPORTS - LAB REPORTS - SCANNED
Page 2
445

Clinical Lab

LABREPORTS

Name: GOMEZ, HECTOR Sex: M Age: 56 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: GROSS, VALERIE CAROL
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-29-2007 12:26	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-29-2007 07:51	GLUCOSE PCX, WHOLE BLOOD	Finished	86	70 - 100		POCT	
11-28-2007 20:52	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-28-2007 15:12	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	

01-07-2008 10:27:18
Page 21
Printed by COL9

Clinical Lab

Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
12-01-2007 07:20	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		137.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.30 MMOL/L	3.50 - 5.00	L	GEN LAB	
	CHLORIDE		103.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		24 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		10 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		114.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		3.0 MG/DL	8.0 - 20.0	L	GEN LAB	
	CREATININE		0.7 MG/DL	0.7 - 1.3		GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.4 MG/DL	8.4 - 10.2		GEN LAB	
	HEMOGLOBIN	Finished	12.0 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT	Finished	37.20 %	42.00 - 52.00	L	GEN LAB	
11-29-2007 12:26	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-29-2007 07:51	GLUCOSE PCX, WHOLE BLOOD	Finished	86	70 - 100		POCT	
11-28-2007 20:52	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-28-2007 15:12	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-28-2007 11:36	GLUCOSE PCX, WHOLE BLOOD	Finished	92	70 - 100		POCT	
11-28-2007 07:53	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-27-2007 21:24	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-27-2007 17:22	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-27-2007 12:43	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-27-2007 08:33	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
11-27-2007 04:01	GLUCOSE PCX, WHOLE BLOOD	Finished	85	70 - 100		POCT	
11-27-2007 00:18	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-26-2007 20:19	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-26-2007 15:47	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-26-2007 11:44	GLUCOSE PCX, WHOLE BLOOD	Finished	156	70 - 100	H	POCT	
11-26-2007 07:52	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
11-26-2007 04:57	GLUCOSE PCX, WHOLE BLOOD	Finished	141	70 - 100	H	POCT	
11-26-2007 04:00	GLUCOSE PCX, WHOLE BLOOD	Finished	61	70 - 100	L	POCT	
11-26-2007 00:04	GLUCOSE PCX, WHOLE BLOOD	Finished	81	70 - 100		POCT	
11-25-2007 21:00	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-25-2007 16:24	GLUCOSE PCX, WHOLE BLOOD	Finished	122	70 - 100	H	POCT	
11-25-2007 13:07	GLUCOSE PCX, WHOLE BLOOD	Finished	132	70 - 100	H	POCT	
11-25-2007 12:01	GLUCOSE PCX, WHOLE BLOOD	Finished	62	70 - 100	L	POCT	
11-25-2007 08:27	GLUCOSE PCX, WHOLE BLOOD	Finished	148	70 - 100	H	POCT	
11-25-2007 05:11	GLUCOSE PCX, WHOLE BLOOD	Finished	127	70 - 100	H	POCT	

446
P493

Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
11-25-2007 04:41	GLUCOSE PCX, WHOLE BLOOD	Finished	69	70 - 100	L	POCT	
11-25-2007 00:28	GLUCOSE PCX, WHOLE BLOOD	Finished	97	70 - 100		POCT	
11-24-2007 21:11	GLUCOSE PCX, WHOLE BLOOD	Finished	102	70 - 100	H	POCT	
11-24-2007 17:04	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-24-2007 13:03	GLUCOSE PCX, WHOLE BLOOD	Finished	84	70 - 100		POCT	
11-24-2007 08:15	GLUCOSE PCX, WHOLE BLOOD	Finished	84	70 - 100		POCT	
11-24-2007 03:40	GLUCOSE PCX, WHOLE BLOOD	Finished	82	70 - 100		POCT	
11-23-2007 23:43	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-23-2007 19:49	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
11-23-2007 16:42	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-23-2007 14:20	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-23-2007 08:31	GLUCOSE PCX, WHOLE BLOOD	Finished	110	70 - 100	H	POCT	
11-23-2007 06:07	GLUCOSE PCX, WHOLE BLOOD	Finished	106	70 - 100	H	POCT	
11-22-2007 23:53	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-22-2007 19:46	GLUCOSE PCX, WHOLE BLOOD	Finished	90	70 - 100		POCT	
11-22-2007 15:34	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-22-2007 11:44	GLUCOSE PCX, WHOLE BLOOD	Finished	112	70 - 100	H	POCT	
11-22-2007 07:48	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
11-22-2007 06:25	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		140.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.90 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		106.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		27 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		7 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		113.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		14.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.6 MG/DL	0.7 - 1.3	L	GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.9 MG/DL	8.4 - 10.2		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		9.720 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		4.02 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.6 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		35.60 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.6 FL	80.0 - 94.0		GEN LAB	
	MCH		28.9 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.6 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.9 %	11.5 - 14.5	H	GEN LAB	

447
P494

Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
*Lab site address details are available to be printed in a separate report.

Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	PLATELET COUNT	Finished					
	PLATELET COUNT		519 K/CUMM	140 - 440	H	GEN LAB	
	MPV		11.70 FL	9.15 - 12.31		GEN LAB	
11-22-2007 04:18	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-22-2007 00:06	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-21-2007 20:20	GLUCOSE PCX, WHOLE BLOOD	Finished	122	70 - 100	H	POCT	
11-21-2007 16:11	GLUCOSE PCX, WHOLE BLOOD	Finished	108	70 - 100	H	POCT	
11-21-2007 12:06	GLUCOSE PCX, WHOLE BLOOD	Finished	116	70 - 100	H	POCT	
11-21-2007 08:05	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-21-2007 04:45	GLUCOSE PCX, WHOLE BLOOD	Finished	127	70 - 100	H	POCT	
11-21-2007 01:20	METABOLIC PANEL, BASIC - BMP	Started					
	SODIUM (NA)		142.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		4.10 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		106.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		30 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		109.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		15.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.5 MG/DL	0.7 - 1.3	L	GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.7 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.4 MG/DL	1.6 - 2.3	H	GEN LAB	
	PHOSPHORUS (PO4)	Finished	4.7 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		8.920 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.92 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.3 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		34.70 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.5 FL	80.0 - 94.0		GEN LAB	
	MCH		28.8 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.6 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.9 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		497 K/CUMM	140 - 440	H	GEN LAB	
	MPV		11.50 FL	9.15 - 12.31		GEN LAB	
	PROTHROMBIN TIME (PT)	Finished					
	PT		15.2 SEC	12.6 - 15.2		GEN LAB	*
	INR		1.16			GEN LAB	

448
P495

Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	APTT	Finished	33.3 SEC	23.3 - 35.7		GEN LAB	*
	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		36.8 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.40	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		47 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		103 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		98.1 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		4.0 MMOL/L	-2.0 - 3.0	H	OR LAB	
	BICARBONATE		29.0 MMOL/L	22.0 - 26.0	H	OR LAB	
11-21-2007 00:24	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
11-20-2007 20:29	GLUCOSE PCX, WHOLE BLOOD	Finished	129	70 - 100	H	POCT	
11-20-2007 15:51	GLUCOSE PCX, WHOLE BLOOD	Finished	133	70 - 100	H	POCT	
11-20-2007 11:48	GLUCOSE PCX, WHOLE BLOOD	Finished	143	70 - 100	H	POCT	
11-20-2007 07:25	GLUCOSE PCX, WHOLE BLOOD	Finished	133	70 - 100	H	POCT	
11-20-2007 03:15	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		36.9 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.42	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		43 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		85 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		97.1 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		2.9 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		27.2 MMOL/L	22.0 - 26.0	H	OR LAB	
	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		137.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		4.20 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		103.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		28 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		132.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		9.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.5 MG/DL	0.7 - 1.3	L	GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.3 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.3 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.5 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					

449
P496

Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	WHITE BLOOD CELL COUNT		9.800 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.80 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		11.0 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		33.40 %	42.00 - 52.00	L	GEN LAB	
	MCV		87.9 FL	80.0 - 94.0		GEN LAB	
	MCH		28.9 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.9 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.6 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		491 K/CUMM	140 - 440	H	GEN LAB	
	MPV		11.80 FL	9.15 - 12.31		GEN LAB	
	PREALBUMIN	Finished	20.3 MG/DL	18.0 - 38.0		GEN LAB	
11-20-2007 00:03	GLUCOSE PCX, WHOLE BLOOD	Finished	131	70 - 100	H	POCT	
11-19-2007 19:39	GLUCOSE PCX, WHOLE BLOOD	Finished	146	70 - 100	H	POCT	
11-19-2007 17:01	GLUCOSE PCX, WHOLE BLOOD	Finished	100	70 - 100		POCT	
11-19-2007 15:52	GLUCOSE PCX, WHOLE BLOOD	Finished	99	70 - 100		POCT	
11-19-2007 15:04	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
11-19-2007 13:57	GLUCOSE PCX, WHOLE BLOOD	Finished	103	70 - 100	H	POCT	
11-19-2007 13:00	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.0 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.39	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		43 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		149 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.5 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		1.3 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.8 MMOL/L	22.0 - 26.0		OR LAB	
11-19-2007 12:59	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-19-2007 12:13	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
11-19-2007 10:54	GLUCOSE PCX, WHOLE BLOOD	Finished	122	70 - 100	H	POCT	
11-19-2007 09:57	GLUCOSE PCX, WHOLE BLOOD	Finished	78	70 - 100		POCT	
11-19-2007 08:52	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-19-2007 08:50	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.4 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.41	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		42 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		83 MM HG	80 - 100		OR LAB	*

450
P497

Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	% O2 SATURATION		96.2 %	96.0 - 97.0		OR LAB	
	BASE EXC/D		1.7 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.9 MMOL/L	22.0 - 26.0		OR LAB	
11-19-2007 07:56	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-19-2007 06:07	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-19-2007 06:05	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		38.2 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.44	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		39 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		114 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		98.7 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		2.2 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.6 MMOL/L	22.0 - 26.0		OR LAB	
11-19-2007 04:30	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		138.0 MMOL/L	135.0 - 145.0		GEN LAB	
	POTASSIUM (K)		3.70 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		105.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		27 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		6 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		105.0 MG/DL	70.0 - 100.0	H	GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		11.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.5 MG/DL	0.7 - 1.3	L	GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		9.0 MG/DL	8.4 - 10.2		GEN LAB	
	MAGNESIUM (MG)	Finished	2.0 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.0 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		8.450 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.38 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		9.5 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		30.00 %	42.00 - 52.00	L	GEN LAB	
	MCV		88.8 FL	80.0 - 94.0		GEN LAB	
	MCH		28.1 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		31.7 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.5 %	11.5 - 14.5		GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		405 K/CUMM	140 - 440		GEN LAB	

451
P498

Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	MPV		11.50 FL	9.15 - 12.31		GEN LAB	
11-19-2007 04:20	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		50 %			OR LAB	
	BODY TEMPERATURE		38.2 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.42	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		40 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		92 MM HG	80 - 100		OR LAB	*
	% O2 SATURATION		96.9 %	96.0 - 97.0		OR LAB	
	BASE EXC/D		1.6 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		25.2 MMOL/L	22.0 - 26.0		OR LAB	
11-19-2007 03:41	GLUCOSE PCX, WHOLE BLOOD	Finished	99	70 - 100		POCT	
11-19-2007 02:33	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-19-2007 00:48	GLUCOSE PCX, WHOLE BLOOD	Finished	89	70 - 100		POCT	
11-18-2007 23:14	GLUCOSE PCX, WHOLE BLOOD	Finished	124	70 - 100	H	POCT	
11-18-2007 20:55	GLUCOSE PCX, WHOLE BLOOD	Finished	105	70 - 100	H	POCT	
11-18-2007 19:31	GLUCOSE PCX, WHOLE BLOOD	Finished	111	70 - 100	H	POCT	
11-18-2007 18:10	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		10L %			OR LAB	
	BODY TEMPERATURE		37.3 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.34	7.35 - 7.45	L	OR LAB	
	PCO2 AT PATIENT TEMP		48 MM HG	35 - 45	H	OR LAB	
	PO2 AT PATIENT TEMP		76 MM HG	80 - 100	L	OR LAB	*
	% O2 SATURATION		94.0 %	96.0 - 97.0	L	OR LAB	
	BASE EXC/D		-0.5 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.9 MMOL/L	22.0 - 26.0		OR LAB	
11-18-2007 18:03	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
11-18-2007 17:02	GLUCOSE PCX, WHOLE BLOOD	Finished	101	70 - 100	H	POCT	
11-18-2007 16:01	GLUCOSE PCX, WHOLE BLOOD	Finished	120	70 - 100	H	POCT	
11-18-2007 15:05	GLUCOSE PCX, WHOLE BLOOD	Finished	95	70 - 100		POCT	
11-18-2007 14:04	GLUCOSE PCX, WHOLE BLOOD	Finished	132	70 - 100	H	POCT	
11-18-2007 13:04	GLUCOSE PCX, WHOLE BLOOD	Finished	156	70 - 100	H	POCT	
11-18-2007 12:18	GLUCOSE PCX, WHOLE BLOOD	Finished	127	70 - 100	H	POCT	
11-18-2007 10:11	GLUCOSE PCX, WHOLE BLOOD	Finished	96	70 - 100		POCT	
11-18-2007 07:51	GLUCOSE PCX, WHOLE BLOOD	Finished	145	70 - 100	H	POCT	
11-18-2007 06:26	GLUCOSE PCX, WHOLE BLOOD	Finished	107	70 - 100	H	POCT	
11-18-2007 04:01	GLUCOSE PCX, WHOLE BLOOD	Finished	92	70 - 100		POCT	
11-18-2007 03:55	METABOLIC PANEL, BASIC - BMP	Finished					
	SODIUM (NA)		135.0 MMOL/L	135.0 - 145.0		GEN LAB	

452
P499

Name: GOMEZ-FRAGOSO, HECTOR Sex: M Age: 27 y
MRN/s: 002581962 ADT
Facility: MUSC Provider: LINCOLN, COURTNEY
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Date	Description	Status	Result	Normal Range	H/L	Site	Cmt
	POTASSIUM (K)		3.60 MMOL/L	3.50 - 5.00		GEN LAB	
	CHLORIDE		107.0 MMOL/L	98.0 - 107.0		GEN LAB	
	CO2 CONTENT (BICARBONATE)		24 MMOL/L	22 - 32		GEN LAB	
	ANION GAP		4 MMOL/L	2 - 11		GEN LAB	
	GLUCOSE, SERUM		96.0 MG/DL	70.0 - 100.0		GEN LAB	
	UREA NITROGEN, BLOOD (BUN)		12.0 MG/DL	8.0 - 20.0		GEN LAB	
	CREATININE		0.5 MG/DL	0.7 - 1.3	L	GEN LAB	
	ESTIMATED GLOMERULAR FILTRATION RATE (eGFR)		>59			GEN LAB	*
	CALCIUM		8.2 MG/DL	8.4 - 10.2	L	GEN LAB	
	MAGNESIUM (MG)	Finished	2.2 MG/DL	1.6 - 2.3		GEN LAB	
	PHOSPHORUS (PO4)	Finished	3.4 MG/DL	2.4 - 4.7		GEN LAB	
	HEM PANEL	Finished					
	WHITE BLOOD CELL COUNT		7.040 K/CUMM	4.800 - 10.800		GEN LAB	
	RED BLOOD CELL COUNT		3.33 M/CUMM	4.70 - 6.10	L	GEN LAB	
	HEMOGLOBIN		9.5 GM/DL	14.0 - 18.0	L	GEN LAB	
	HEMATOCRIT		29.70 %	42.00 - 52.00	L	GEN LAB	
	MCV		89.2 FL	80.0 - 94.0		GEN LAB	
	MCH		28.5 UUGM	27.0 - 31.0		GEN LAB	
	MCHC		32.0 GM/DL	30.7 - 34.4		GEN LAB	
	RDW		14.9 %	11.5 - 14.5	H	GEN LAB	
	PLATELET COUNT	Finished					
	PLATELET COUNT		377 K/CUMM	140 - 440		GEN LAB	
	MPV		11.50 FL	9.15 - 12.31		GEN LAB	
	ARTERIAL BLOOD GAS	Finished					
	FRACTION OF INSPIRED OXYGEN		40 %			OR LAB	
	BODY TEMPERATURE		37.8 DEG C			OR LAB	
	PH AT PATIENT TEMP		7.43	7.35 - 7.45		OR LAB	
	PCO2 AT PATIENT TEMP		38 MM HG	35 - 45		OR LAB	
	PO2 AT PATIENT TEMP		126 MM HG	80 - 100	H	OR LAB	*
	% O2 SATURATION		99.0 %	96.0 - 97.0	H	OR LAB	
	BASE EXC/D		1.1 MMOL/L	-2.0 - 3.0		OR LAB	
	BICARBONATE		24.7 MMOL/L	22.0 - 26.0		OR LAB	
11-18-2007 03:18	GLUCOSE PCX, WHOLE BLOOD	Finished	117	70 - 100	H	POCT	
11-18-2007 02:39	GLUCOSE PCX, WHOLE BLOOD	Finished	109	70 - 100	H	POCT	
11-18-2007 01:28	GLUCOSE PCX, WHOLE BLOOD	Finished	114	70 - 100	H	POCT	
11-17-2007 23:57	GLUCOSE PCX, WHOLE BLOOD	Finished	104	70 - 100	H	POCT	
11-17-2007 22:04	GLUCOSE PCX, WHOLE BLOOD	Finished	113	70 - 100	H	POCT	
11-17-2007 19:27	GLUCOSE PCX, WHOLE BLOOD	Finished	118	70 - 100	H	POCT	

453
P500