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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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DECISION AND ORDER OF THE

SOUTH CAROLINA WORKERS' COMPENSATION COMMISSION

WCC FILE NO. 0717624

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| Hector G. Fragosa,<br>Employee,<br>Claimant,<br>vs.<br>Kade Construction, LLC,<br>Employer,<br>and<br>Key Risk Management Services, Inc.,<br>Carrier,<br>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.<br><br>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.

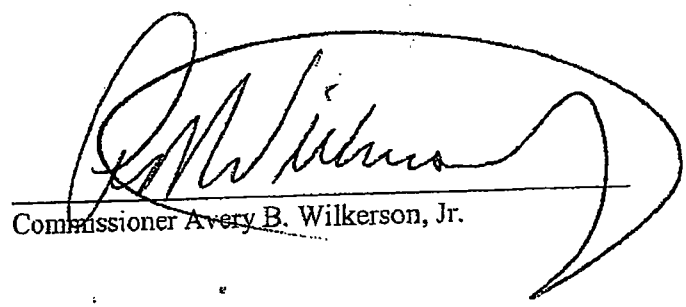
## VII. ORDER/AWARD

**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.

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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.

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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

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Appeal From The Workers' Compensation Commission

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

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**AFFIRMED IN PART AND REMANDED**

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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.

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**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.

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[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

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ORDER

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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

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ORDER

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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

MUSC
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Medical University of South Carolina
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.

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

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

**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

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 #: 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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Radiology Report

**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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Charleston, SC
843-792-2123
**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.

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**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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**Radiology 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

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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**Radiology Report**

**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

Transcribed by: Tech IntTalk

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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<br>Left ☒ Absent ☐ Present |
| Coor | ☐ NAT | ☐ Normal Rt FN ☐ ABN<br>☐ 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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# 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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**Trauma Center Initial Patient Evaluation**
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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: _____

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**Trauma Center Initial Patient Evaluation**
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**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: unable to quantify 2° to intubation + sedation pts
Motor Response: 1 pts
Total GCS Score: 3T pts

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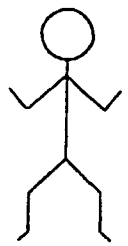
| Vascular Examination | | | |
|---|---|---|---|
| Vessel | Lt | Rt | Comments |
| Carotid | ✓ | ✓ | |
| Brachial | | | |
| Radial | | | |
| Ulnar | | | |
| Femoral | ✓ | ✓ | |
| Popliteal | | | |
| Dorsalis Pedis | ✓ | ✓ | |
| Posterior Tibial | ✓ | ✓ | |

| 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**
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**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

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**Trauma Center Initial Patient Evaluation**
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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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* N R S R E C R D *

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 1 2007

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**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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

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*NRSRECRD*

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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 1 2007

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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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**24 HOUR CRITICAL CARE PATIENT RECORD** Date _____

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**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 CXR Rad A-Line Placed 2200 Dr. Brown Aware of H+H. orders Received MW 2330 Dr. Brown Aware of Present Labs MW 0200 NS Hourly Neuro Assessment Performed by Dr. Krishna. MW 0430 Dr. Brown Aware of Current Labs. Dr. Brown Performed a Pedal Exam on Pt MW 0700 Cc from ICS Report Given MW

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 01 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 | 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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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



## 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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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 01 2007

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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 |

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 1 2007

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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: 11/1/07

| | 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**

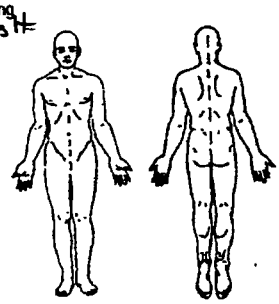
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☒P Pain ☐A ☒P Receiving analgesic therapy Fentanyl 3H

(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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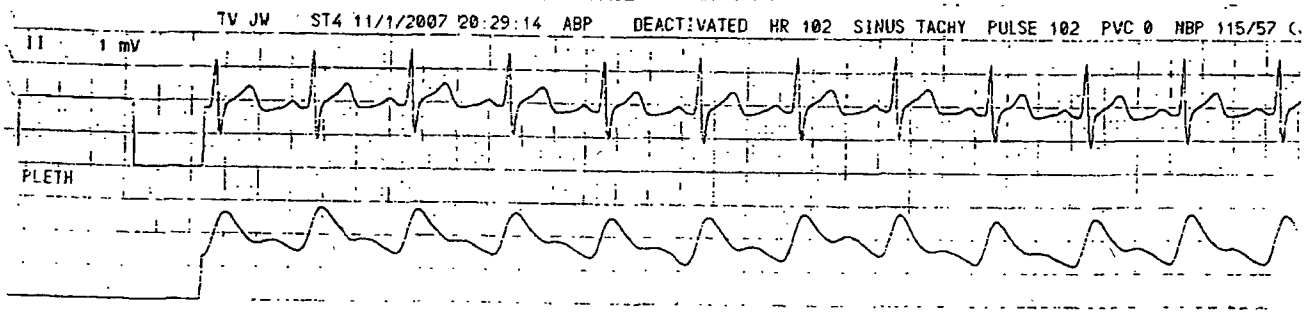
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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THIS SPACE MONITOR STRIPS




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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 01 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 | | | | | | |
| 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 01 2007



## 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 | | | | | | |

UP# 411230 rev 8/03

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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



## 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
Adm:11/01/07 M:2581962

# 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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*NRSRECRD*

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

(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)

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**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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

(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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# 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 | $PO_2$ / $PCO_2$ | $HCO_3$ / $O_2$SAT | 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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(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: __/__/__

| | 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

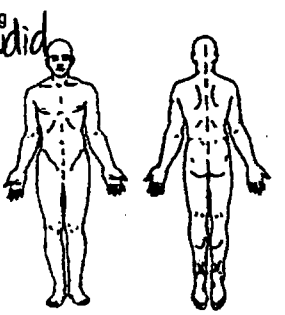
☐A ☐P **WNL:** No signs / symptoms or complaint of pain, nausea, itching, fever, sweating, chills or difficulty sleeping. Absence of analgesic therapy.

**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

UP# 411230 rev 8/03

*NRSRECRD*

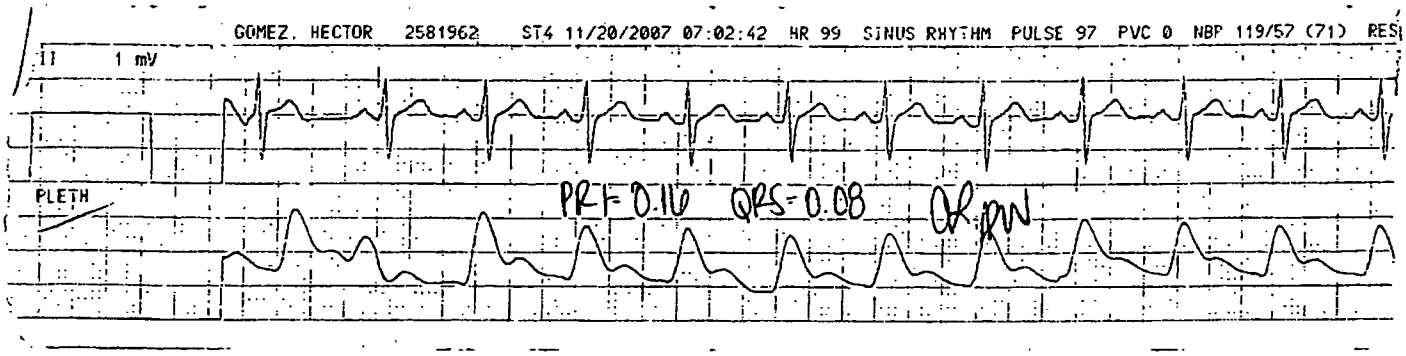
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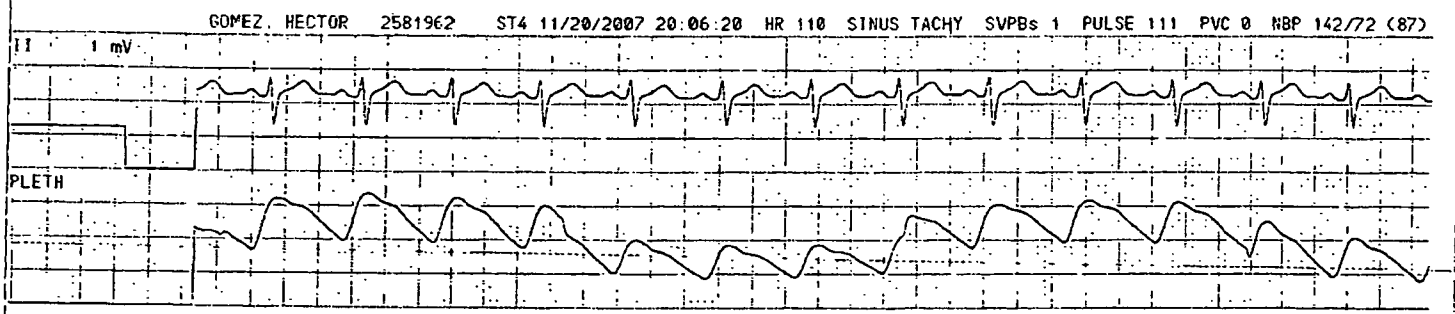
P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

(STAMP PLATE)

## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 5 of 12




UP# 411230 rev 8/03

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

(STAMP PLATE)

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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

(STAMP PLATE)



## 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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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

(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

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# 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 |

prgrecrd1

OTE 700222 Rev. 9/06

1525

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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

**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 | |
|---|---|---|
| 11/1/07 | 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 AM
2. Cardio: Pt stable & mildly tachy, Will Place Holter for [illegible] monitoring & Hypotensive PRN / HR 140
3. Resp: Pt Intubated & Sedated will wean ventilator per protocol in AM & ABG prn & CXR prn as ordered
4. GI - Pt Heme (-), in ED, Will keep NPO o/N
5. Renal: Foley in place, Stable, Good UOP
6. FEN - Pt on
7. Endo - SSI
8. Heme - PRBC & Platelets cont to be Will recheck Hct & transfuse if < 30, maintain Hct
9. SCD's for DVT & PPI for GI
10. Pt on Cefotaxime & Vanc for Skull fx

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(531)

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GOMEZ
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Adm:11/01/07 M:2581962

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Version: 3 Version Date: 9/06

Patient Name _____
MRN _____
STAMP PLATE AREA

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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 | |
|---|---|---|
| 11/2/07 | | 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

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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 |
|---|---|---|---|
| | | | |

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007

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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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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

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)

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NOV 02 2007

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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 | | | | | | | |

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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



## 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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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007

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

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007

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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: 11/1/07

| | 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.

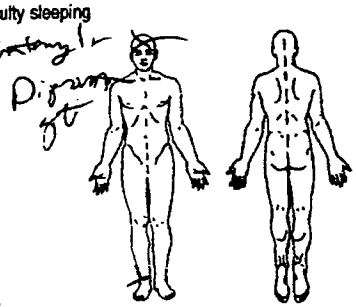
**Abnormal Findings**

☐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*

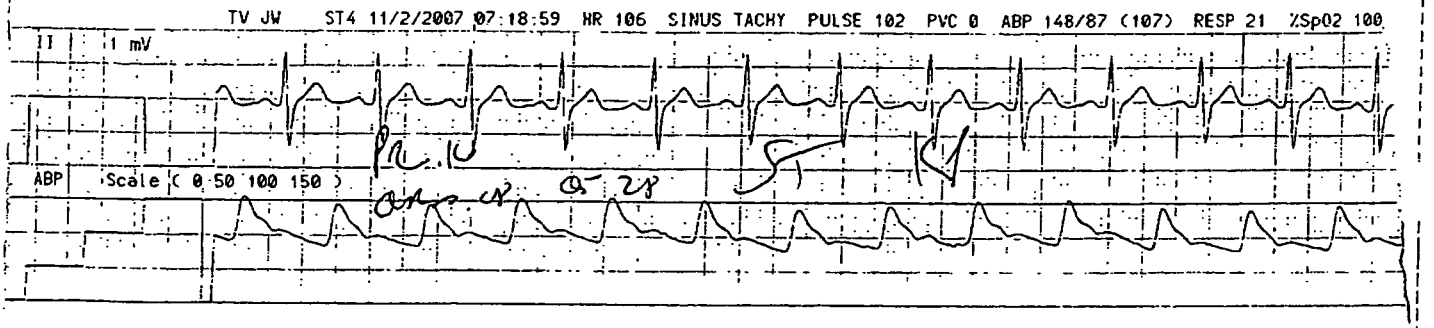
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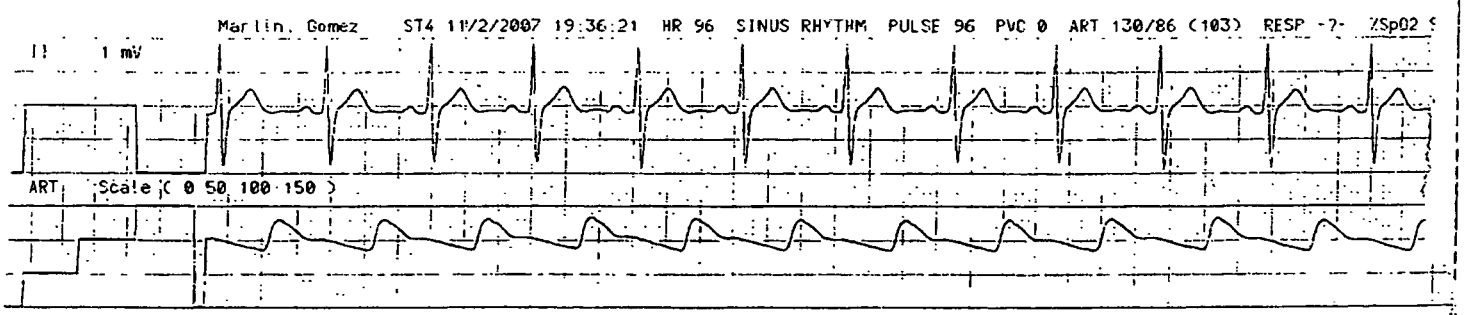
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 02 2007



THIS SPACE MONITOR STRIPS




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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 2 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

**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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NOV 02 2007

## 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**.

MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA

*PRGRECRD*

**Adult Nutrition Progress Note**
**Assessment for Nutrition Support**
Page 1 of 1

Form Origination Date: 9/04
Version: 3 Version Date: 4/05

P490943644 DOB:01/01/1851 U U
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"

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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 | |
|---|---|---|
| 12/11/07 | 02:30 | NSVRS<br>0 acute events<br>V - 109 18 123/85 100% on vent<br>O/E - sedated intubated<br>CVS RRR<br>Resp - b/l chest rise<br>CNS - EM VBT MS<br>PERRL.<br>bowel sounds b/l UE,<br>no withdraws b/l LE<br>A&P - CHF c O2 F-P should go c pacing<br>c CVP, spo2 stable, cont. c<br>current plan, cont to follow<br>[illegible]<br>1538 |

prgrecrd1 OTE 700222 Rev. 9/06

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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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| | | | |
|---|---|---|---|
| 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 | |
|---|---|---|
| 6/2 | | Ortho<br>S: intubated<br>O: (R) UE: splint C/D/I<br>toes warm<br>cap refill <2 sec<br>- small open lacerations over 4th & 5th<br>Distal phalanx<br>- (R) UE in splint<br>A/P: (R) 1-5 phalanx fx, 4 & 5 grade I open<br>(R) Ulnar fx<br>1) cont. Ancef<br>2) Sling (R) UE<br>3) we will discuss if operative<br>intervention is indicated<br>M Z<br>15228 |
| 11/2/7 | | Ortho - Staff<br>Intubated, Sedated, Localized<br>37.2 95 139/76 95% PRVC<br>(R) shoulder @ swelling, skin intact<br>(R) UE in splint, Toes perfused, CR ~ 2-3 sec.<br>Complex. Lac 5th toe > dry blood-<br>Small lac - great Toe<br>Xrays → Fx's of great → 5th toe phalanges.<br>(R) clavicle (midshaft) fx. |

prgrecrd1 OTE 700222 Rev. 9/06

*PRGRECRD*

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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

**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 | |
|---|---|---|
| | | A/P (1) CHI ± cranial Fx<br>(2) (R) closed clavicle shaft Fx<br>(3) (R) I open foot Fx's.<br>– Had promised I+D of small open and (R) foot in ED on admission.<br>– will cont IV abx + splint for now.<br>– Plan to I+D formally ± CRPP Toe Fx's when neurologically & HD stable.<br>– CCU team aware of plan & will notify us when he is safe to proceed. |
| 11/1/07 | | Attending - Trauma<br>Lacerations<br>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
Adm:11/01/07 M:2581962

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 | |
|---|---|---|
| 11/2/07 | 6PM | ortho postop<br>intubated, stable<br>$36^9$ 83 141/90 & 10%<br>/525 VOP<br>sedated, paralyzed<br>RE splint intact, TRC adequately perfused, good color, cap refill <2s<br>cannot assess movement, neuro exam<br>2E not tense, all dressings clean-dry<br>A/P - s/p IGD, CRPP, Nailed Repair T8, T9<br>- will obtain better neuro exam when responsive, non-paralyzed<br>- cont Abx<br>- wee follow<br>Craig Colton ISMAS |
| 11/3/07 | 01:35 | NSURG<br>ϕ acute events<br>V - $37^9$ 85, 18, 143/83, 100% on PR VC, 18, 40%, 550, 5<br>O/E sedated, intubated<br>CV3 - RRR 2507/2251<br>Resp - b/l chest rise<br>Abd - soft<br>CNS - E2 V[illegible] M5<br>briskly tracking b/l UE, WD b/l LE<br>Pupils b/l small NR<br>A/P: HI c CT FP skull fx - open, GCS<br>- SFx stable. Cont. c current plan<br>Cont to follow.<br>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

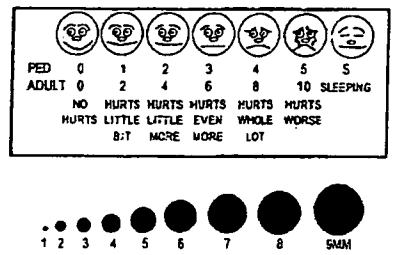
**VERBAL**
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

**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 # _____



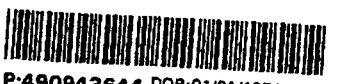

| TIME | TEMP | PULSE | SPON / VENT RESP | CUFF BP | A-LINE BP | MAP / PCWP | CVP | PA | CO / CI | SVR | $S_vO_2$ | ICP HI / LOW | DAILY WEIGHT / TIME / LOSS/GAIN | PAIN / SEDATION | PUPILS SIZE R | PUPILS SIZE L | PUPILS REACTION R | PUPILS REACTION L | MOTOR | VERBAL |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 08 | 37.2 | 113 | 18 / | 147/83 | | 96 | | | | | 98 | | | | | | | | | |
| 09 | 37.1 | 120 | 18 / | 134/85 | | 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/ | 101 | | | | | 100 | | | | | | | | | |
| 17 | 38.2 | 116 | 0 / 18 | | 122/ | 88 | | | | | 100 | | | | | | | | | |
| 18 | 37.4 | 116 | 0 / 18 | | 168/ | 116 | | | | | 100 | | | | | | | | | |
| 19 | 37.3 | 114 | 0 / 18 | | 150/ | 107 | | | | | 100 | | | | | | | | | |
| 20 | 37.6 | 103 | 0 / 18 | | 158/ | 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/ | 109 | | | | | 100 | | | | | | | | | |
| 01 | 37.4 | 91 | — / 18 | | 159/ | 106 | | | | | 100 | | | | | | | | | |
| 02 | 37.1 | 91 | — / 18 | | 134/ | 98 | | | | | 100 | | Bath, Linen ☐ | | | | | | | |
| 03 | 37.2 | 90 | — / 18 | | 154/ | 105 | | | | | 100 | | Labs | | | | | | | |
| 04 | 36.9 | 87 | — / 18 | | 147/ | 100 | | | | | 100 | | | | | | | | | |
| 05 | 37.1 | 84 | — / 18 | | 152/79 | 102 | | | | | 100 | | | | | | | | | |
| 06 | 36.9 | 82 | — / 18 | | 149/ | 100 | | | | | 100 | | | | | | | | | |
| 07 | 36.9 | 83 | — / 18 | | 149/74 | 95 | | | | | 100 | | | | | | | | | |

* - agonist agave

UP# 411230 rev 8/03

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NOV 0 3 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 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 3 2007

page 2 of 12

(STAMP PLATE)

P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

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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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** _____ (STAMP PLATE)

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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____



NOV 0 3 2007

P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
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 | 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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P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962
(STAMP PLATE)

NOV 03 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 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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*NRSRECRD*

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GOMEZ
HECTOR
Adm:11/01/07 M:2581962

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 3 2007

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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 | | AV / PH | $PO_2$ / $PCO_2$ | $HCO_3$ / $O_2$SAT | | 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 |

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NOV 03 2007

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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: / /

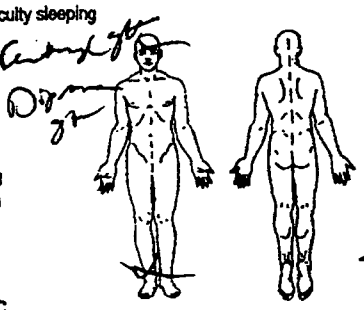
| | Site | Appearance | Dressing | Blood Return |
|---|---|---|---|---|
| A | | | | |
| P | | | | |

## 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

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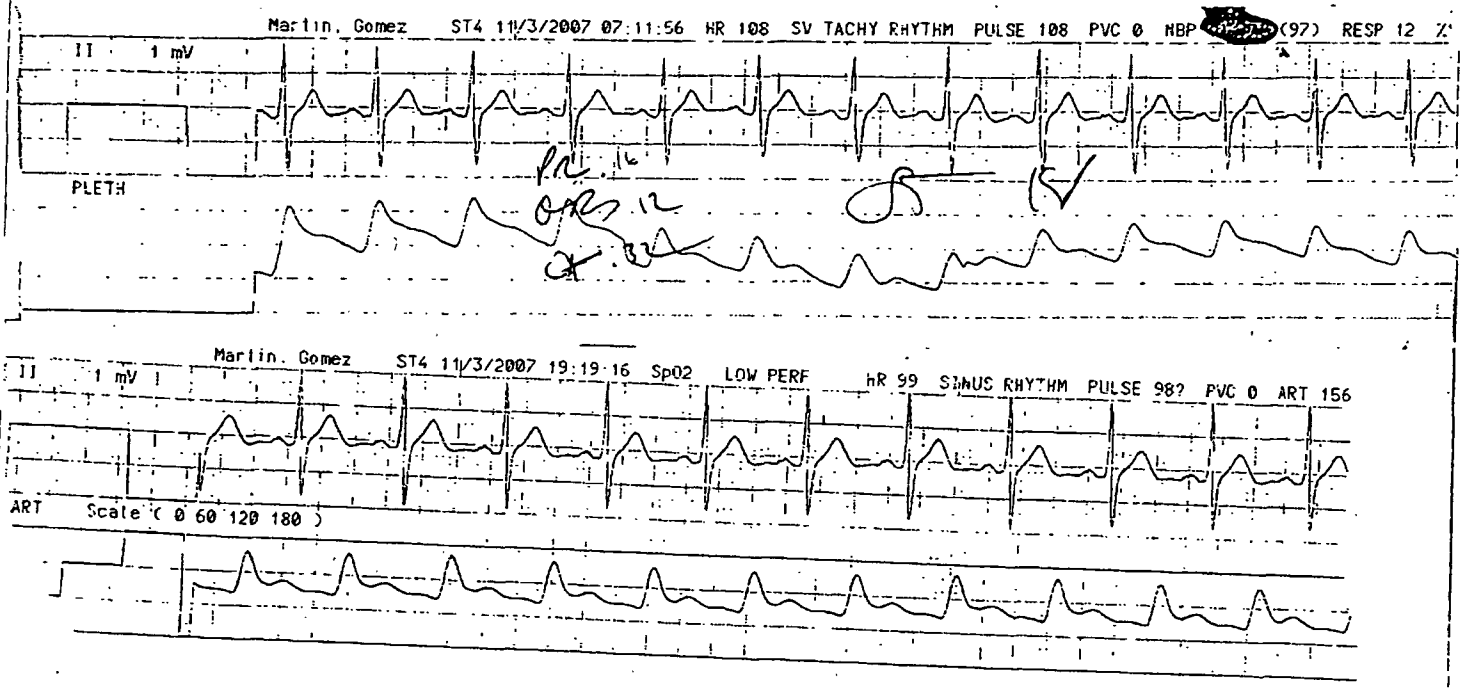
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 03 2007

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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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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 03 2007

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### 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 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ |

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# 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"

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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:* 3-5 mm
*Skin:* Intact
*Psych:*
*Other:* INR - 1.9 PTT 109 Ca 8.4 Mg 2.2 Phos 4.1 BG 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. CHF c EDH ☐New ☐Improved ☒Unchanged ☐Worsening
3. S-process fx C5, T1 ☐New ☐Improved ☒Unchanged ☐Worsening
4. T-process fx - R-sided ☐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. Cardio - Continue Nicardipine gtt for SBP < 140
3. CV - Q1 sets
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 / Clafaxin 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<br>S: ↓ cooperation c exam<br>O: (R)LE: toes warm<br>cap refill < 2 sec<br>pins intact<br>POD #1 primary (R) toes 1, 2, 3, & 5<br>1) NWB (R)LE<br>2) Cont. to follow<br>3) Post elevate (R)LE<br>RL 22<br>15228 |

prgrecrd1

OTE 700222 Rev. 9/06

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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 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
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 #: 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

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

*NRSRECRD*

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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

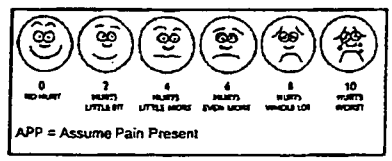
**VERBAL**
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

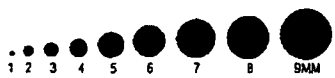
**EYES**
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

**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 |

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## 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 04 2007

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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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**24 HOUR CRITICAL CARE PATIENT RECORD** Date _____
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**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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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 | 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 04 2007

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## 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

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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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# 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 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**

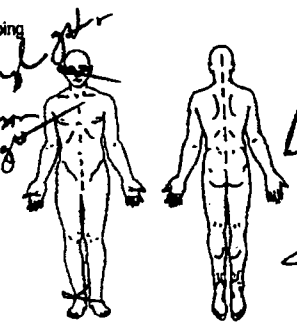
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(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

UP# 411230 rev 8/03

*NRSRECRD*

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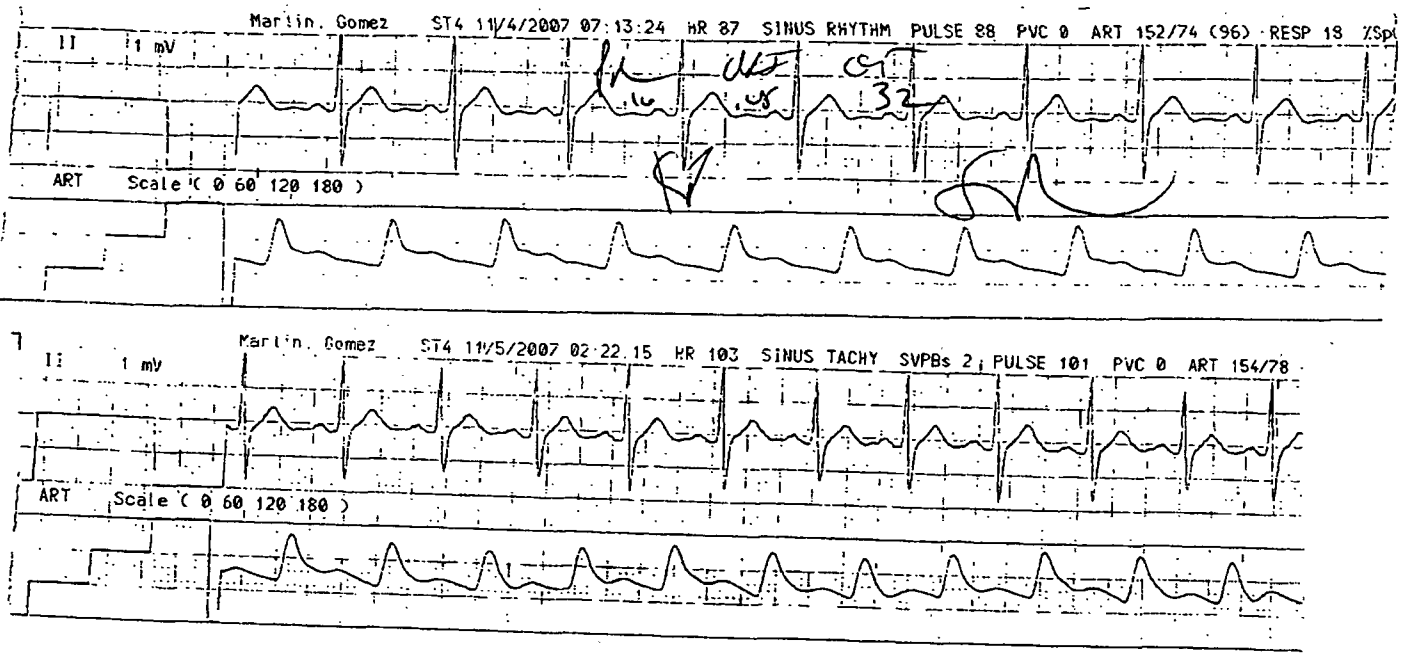
NOV 04 2007

P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

page 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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P:490943644 DOB:01/01/1851 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962
(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*

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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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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:

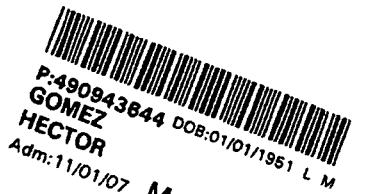
Authenticating Radiologist: STEPHEN SCHABEL

Date Authenticated: 11/5/2007

Transcribed by: Tech IntTalk

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**24 HOUR CRITICAL CARE PATIENT RECORD** Date _____

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**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

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 5 2007

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

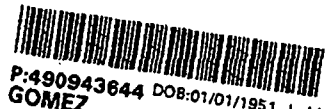
IV SOLUTIONS / ADDITIVES

| 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 |

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**24 HOUR CRITICAL CARE PATIENT RECORD** Date _____
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**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

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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 | | | | | | | | | | | | | | |

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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 _____

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## 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) |

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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 |

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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 _____



## 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.

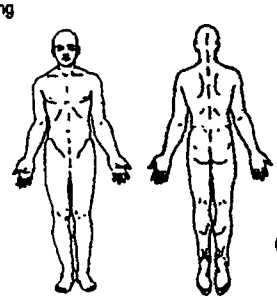
**Abnormal Findings**

☐ 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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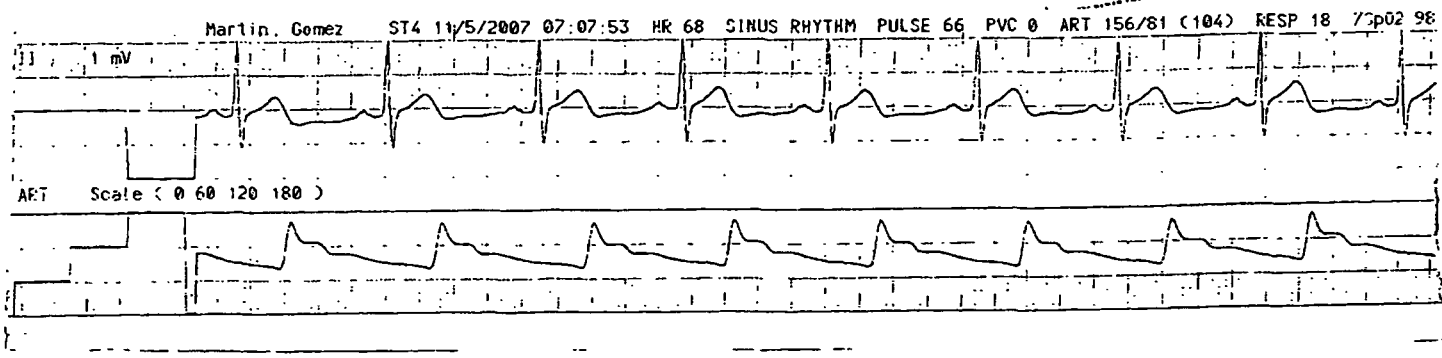
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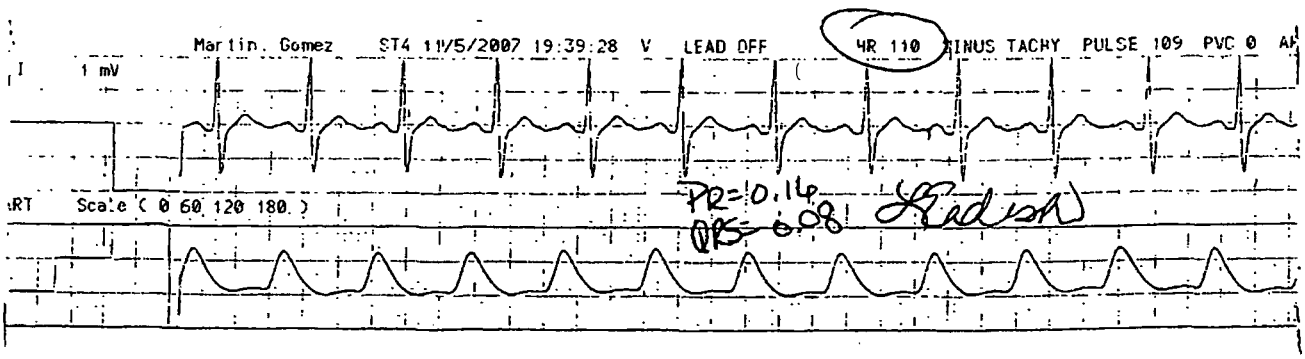
## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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THIS SPACE FOR MONITOR STRIPS NOV 05 2007

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




UP# 411230 rev 8/03

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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 _____



## 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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## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 05 2007

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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 | | | | |
| 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 05 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

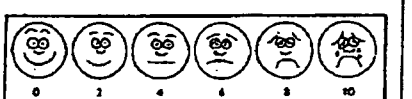
**VERBAL**
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

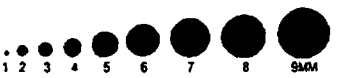
**EYES**
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

**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"

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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

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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 / $MSO_4$ | $MgSO_4$ |

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 | |
|---|---|---|
| | | 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] |

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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

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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 / $MSO_4$ | $MgSO_4$ |

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 | |
|---|---|---|
| | | 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<br>97? 68-114 150/62 1492/13275<br>PE Eyes PERRL<br>Ⓟ Cayl Ⓢ Sc Ⓚ Karen<br>Lue Ⓑ LLE<br>VID Ⓛ LE RLE cast<br>C-collar in Pl<br>P/P: sp MVC - skull fx no intracranial bleed<br>- cont c-collar |
| 11/5/07 | 1518 | |
| 11/5/07 | 1600 | Ortho:<br>I: Intubated, sedated<br>O: R foot in splint, elevated<br>2-5 toe slow CR. warm skin color dark Dopplers @ DP. PT.<br>S/P: percutaneous primary @ 1-5 toe fx.<br>possible venous congestion<br>- loosening splint<br>- 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%

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**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

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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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**Medical University of South Carolina**
**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:

**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 10:42 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 *

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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

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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 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 _____

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**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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## 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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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 | O2SAT | HGB | RBC | PTT | INR | K | CO2 | BUN | CA | PHOS | | | |
| V | PRVC | 55 | 5 | | | | A | 95 | 39 | | | | | | | | | | | | 08 |
| | 18 | 450 | 20 | | | | 7.45 | 39 | 99 | | | | | | | | | | | | 09 |
| | | | | | | | | | | | | | | | | | | | | | 10 |
| | | | | | | | | | | | | | | | | | | | | | 11 |
| | | | | | | | | | | | | | | | | | | | | | 12 |
| | | | | | | | | | | | | | | | | | | | | | 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 | | | 1.2 | 139 | 119 | 68 | 0.7 | 2.6 | | | 02 |
| | | | | | | | | | | 37 | | | | 3.1 | 27 | 19 | 2% | 0.5 | | | 03 |
| | | | | | | | | | | 21 | 8.7 | | | | | | | | | | 04 |
| | | | | | | | | | | 0.8 | 24 | | | | | | | | | | 05 |
| | | | | | | | | | | | 17 | | | | | | | | | | 06 |
| | | | | | | | | | | | 26 | | | | | | | | | | 07 |
| | | | | | | | | | | | 203 | | | | | | | | | | |
| | | | | | | | | | | | 1.3 | | | | | | | | | | |

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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: 11/05

| | 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.*

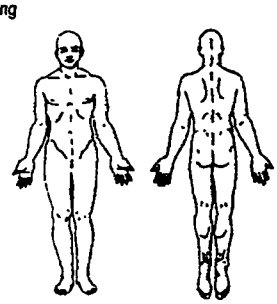
**Abnormal Findings**

☐ 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*

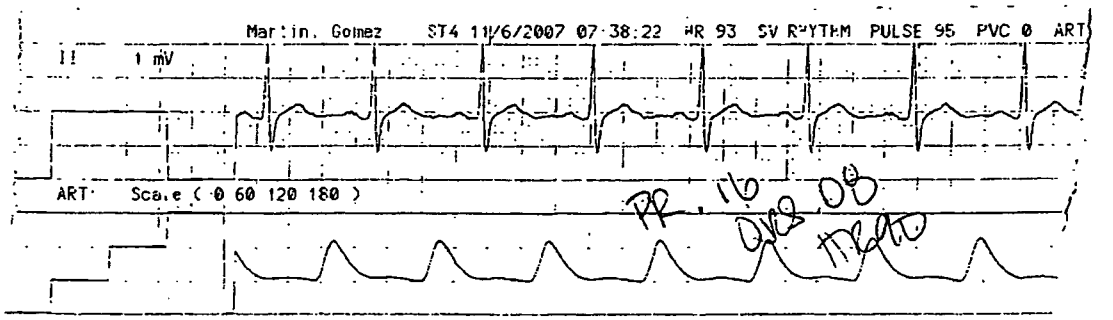
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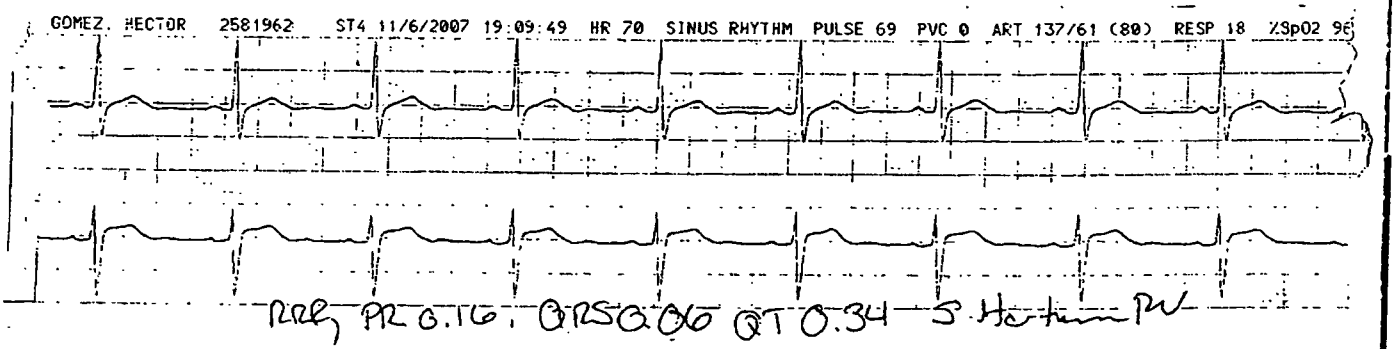
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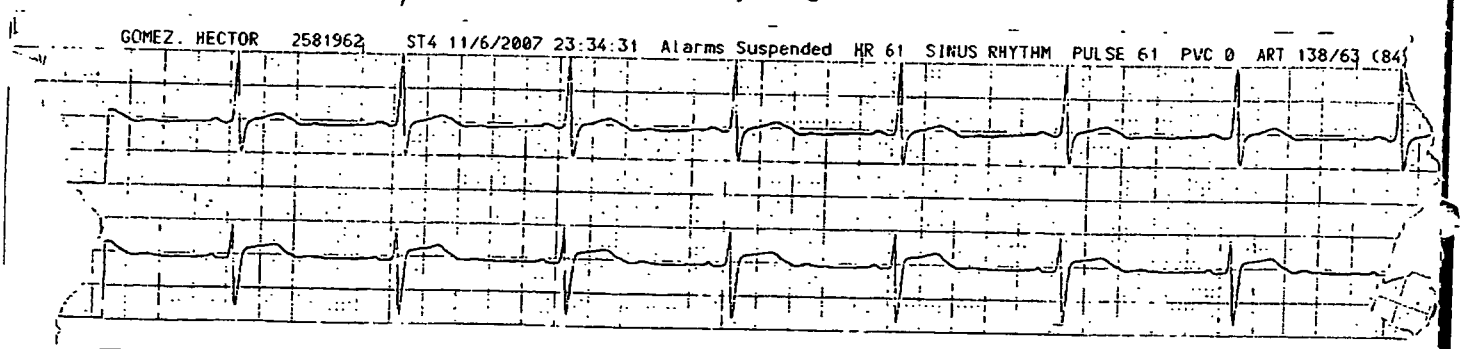
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THIS SPACE MONITOR STRIPS




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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 _____

**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 |

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 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

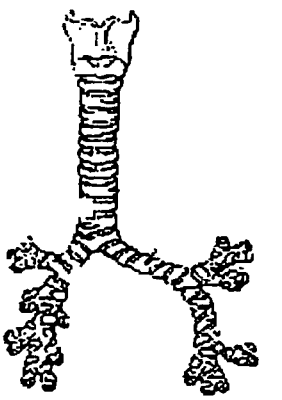
| Procedure: | Drug | Dose | Route |
|---|---|---|---|
| 1. | | | |
| 2. | Ds. cursin / notes | | |
| 3. | | | |

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

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 #: 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

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 #: 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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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 #: 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 *

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 7 2007

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**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

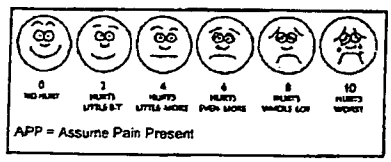
VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

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 | | | | | | | | | | |

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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 7 2007

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### 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 | | |
| | | | |
| | | | |

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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 7 2007

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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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**24 HOUR CRITICAL CARE PATIENT RECORD** Date NOV 07 2007



**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 _____

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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 (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 _____

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## 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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**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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 7 200?

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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: 11/6/07

| | 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.

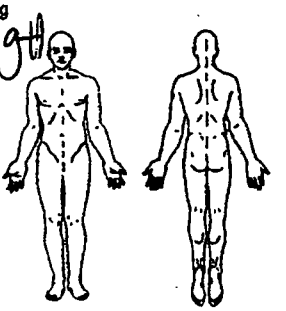
**Abnormal Findings**

☐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 *

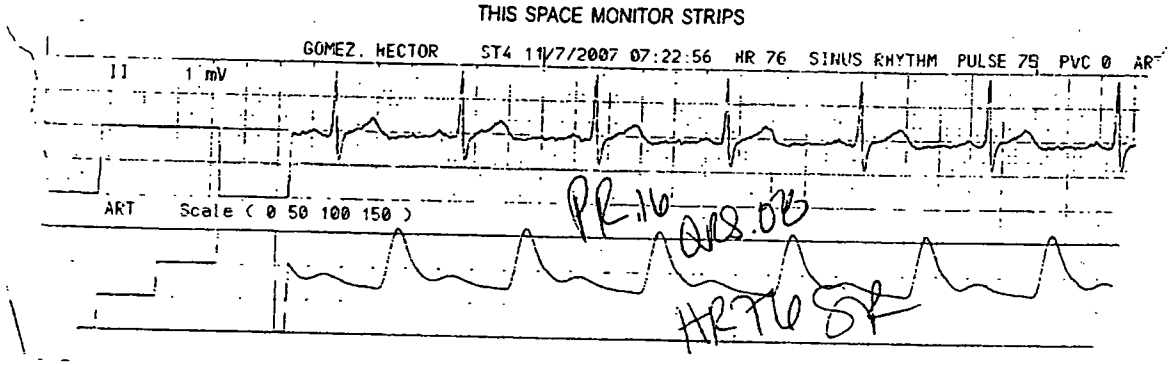
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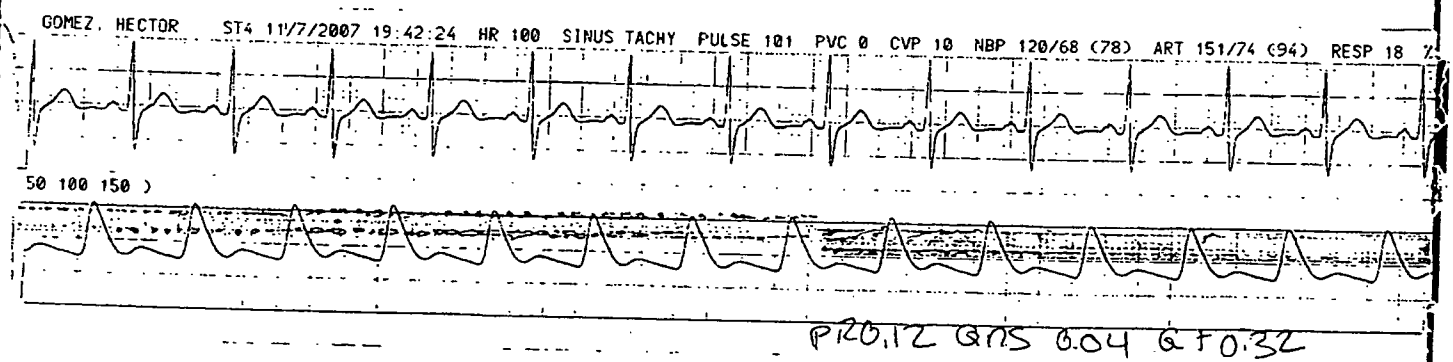
P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 07 2007

page 5 of 12

THIS SPACE MONITOR STRIPS




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(STAMP HERE)

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 07 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 | ✓ (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**.

UP# 411230 rev 8/03

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NOV 0 7 2007

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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 | 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 | ✓ | ✓ | ✓ | ✓ | ✓ |

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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 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:**<br>Blood return in all lumens ☒ Yes ☐ No<br>Procedure complications ☐ Yes ☒ No<br>Biopatch applied ☒ Yes ☐ No<br>Sterile dressing applied ☒ Yes ☐ No | Time procedure completed: 1515<br>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<br>Ø acute events<br>VS -37, 97, 18, 66/22 100% PRVC, 18, 35%, 650 6<br>OTE sedated / intubated<br>CNS RRR 4/sm/2000<br>Resp b/l chest rise<br>Abd soft NTND<br>GNS - ↓2 V/Ø MS<br>Extremities b/l UE<br>middle drawn b/l LE<br>PSRL<br>AM. MRI c CBC/coag fx. Ø √ CT head from this AM. Admit flex/ext c spine<br>Wounds. Cont to follow<br>Keith<br>1530 |

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 Nam
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 | |
|---|---|---|
| 11/7/07 | 6 10 AM | ortho<br>µ acute events<br>37° 70 134/66 18 97% intubated<br>sedated, nonresponsive<br>RLE: strong DP pulse<br>toes 2-5 remain blue, demarcation unchanged<br>pins intact<br>A/P s/p percutaneous pinning of ⑤ 1-5 toe fx<br>- venous congestion likely is ischemic origin but arterial supply to foot present & good DP/PT<br>- cont to observe, loosened splint yesterday<br>- will discuss Dr. Woolfe<br>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

**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 |
|---|---|---|
| 11/7/01 | 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:

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 | |
|---|---|---|
| 11/1 | | 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 |

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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

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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:**

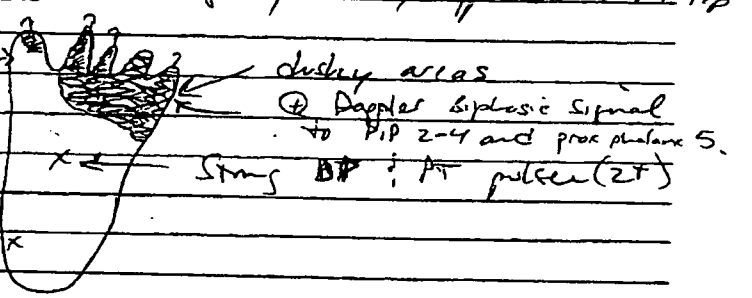
These abbreviations are prohibited in ANY FORM (i.e., upper or lower case, with or without periods):

| | | | |
|---|---|---|---|
| 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 | |
|---|---|---|
| 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

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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 #: 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

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# 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 | | | | | | | | | |

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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 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 | | |
| | | | |
| | | | |

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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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 2007



**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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 2007



## 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.

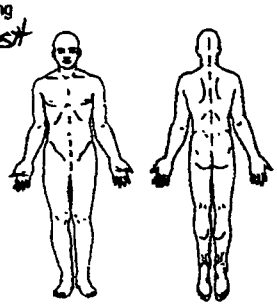
**Abnormal Findings**

☐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

UP# 411230 rev 8/03

* N R S R E C R D *

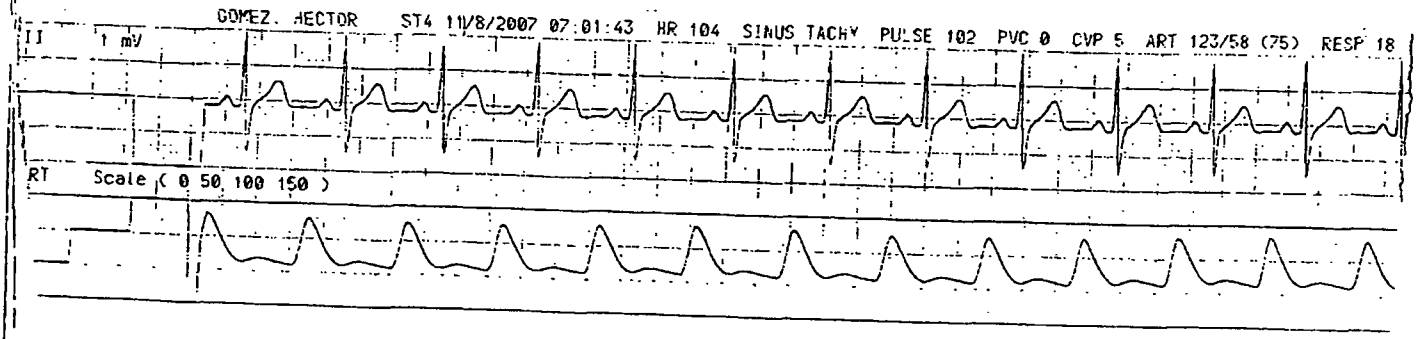
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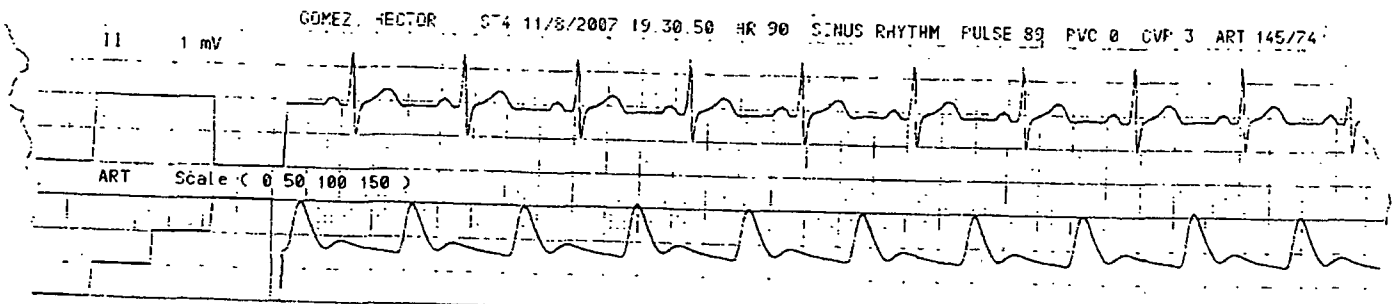
P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 2007

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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 8 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 | 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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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 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**.

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: 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

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 | |
|---|---|---|
| 11/6/07 | 1640 | S/O/G/A<br>⊖ acute events - Gas was poor, $FiO_2$ ↑ to 60%. ⊖ other issues<br>38.4 38.6 97 18 121/60 95%<br>2430 \| 5850<br>Gen: NAD, intubated sedated ⊖f/c<br>HEENT: NG/ET in place; ⊕ copious drainage from L nostril<br>Neck: Mi/amic) in place<br>CV: RRR ⊖ M/G/R L 4: 5<br>Lungs: Coarse BS throughout<br>Abd: soft NT/ND ⊕BS<br>Extrem: RLE toes 2-5 dusky - heating pads in place, ⊕ DP and PT Elevated on wedge.<br>Labs<br>7.44/46/73/29.7 @ PRVC 550/18/10/60%<br>146/109/21/98 8.6<br>3.5/30/1 7.3<br>4.8<br>A/P: 77 M/O MVA s/p BFT Head & open skull fx.<br>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<br>2. CV: ⊖ issues<br>3. ↑ Neural drainage. Will plan of ICP face/stress if ⊖ improvement<br>4. ID - febrile on vanc + Zosyn. (cult ⊕ c GNR.<br>5. Optho: Toes unchanged. on the following. Will allow toes to declare themselves. |

prgrecrd1

OTE 700222 Rev. 9/06

*PRGRECRD*

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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 *

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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

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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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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

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**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

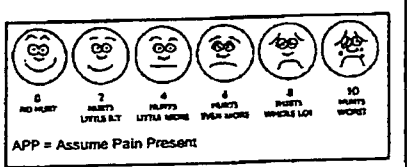
**VERBAL**
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

**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 | | | | | | | | | | |

UP# 411230 rev 8/03

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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* _____

**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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### 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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## 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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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 |

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HECTOR
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**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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NOV 0 9 2007

# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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## 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 | | | | |

UP# 411230 rev 8/03

*NRSRECRD*

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 9 2007

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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, 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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 | (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**

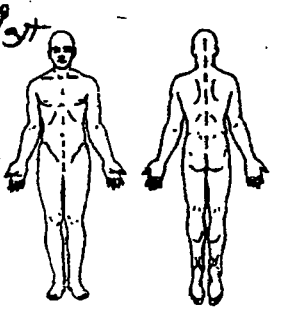
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☑P Receiving analgesic therapy Dilaudid gtt

(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

UP# 411230 rev 8/03

*NRSRECRD*

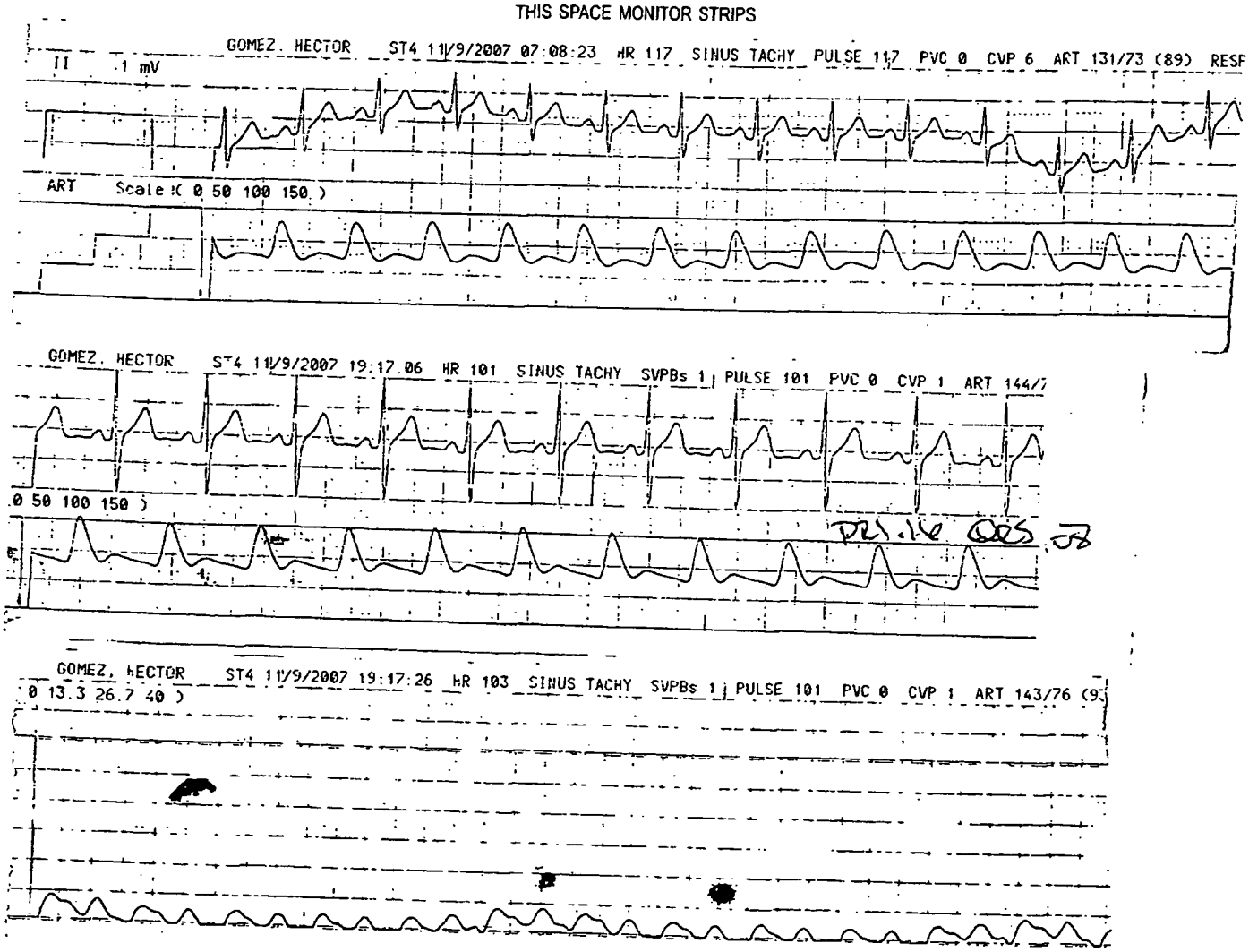
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HECTOR
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 0 9 2007



THIS SPACE MONITOR STRIPS




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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<br>Ø events overnight<br>38° 114 "7/77 (87) 95% vent<br>sedated, intubated<br>RLE - toes unchanged from previous exam<br>demarcation line not traveling.<br>A/P POD #3 5/8 pinning ® 2-5TH toe fx from crush injury<br>- toes likely devascularized from crush injury.<br>- cont to wait for toes to declare themselves.<br>- watch for S/S of infection<br>- await extubation<br>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.<br>Gay Sellers 1566 |

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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 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 / $MSO_4$ | $MgSO_4$ |

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 | | 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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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: 11-9-07 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

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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
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Patient Name
MRN

STAMP PLATE AREA

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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 | |
|---|---|---|
| 11/9/07 | 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<br>Ø acute issues overnight<br>37° 100 124/92 18 95% vent<br>sedated, intubated<br>RLE: DP strong to foot, toes still warm<br>2-5 toes with worsening color, demarcation unchanged<br>unable to assess sensory / motor fxn<br>a/p s/p crush injury to Rt foot<br>- wound 2-5 toes are becoming necrotic. No intervention, will have to wait for them to declare + decide future tx @ that time. Cont elevation<br>- await extubation to further evaluate motn / sensory fxn.<br>Amy Fletcher 15668 |
| | Am | |

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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 #: 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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MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

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**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

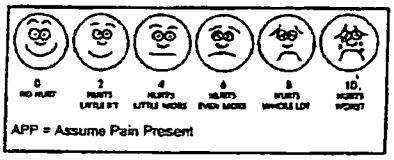
VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

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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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 10 2007

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### 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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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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**24 HOUR CRITICAL CARE PATIENT RECORD** Date _____

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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 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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## 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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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 | $PO_2$ $PCO_2$ | $HCO_3$ $O_2$SAT | 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 _____

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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: 11/6/07

| | 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**

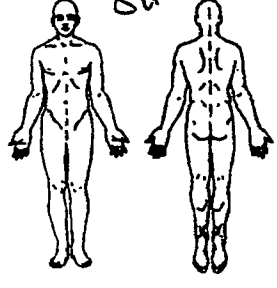
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(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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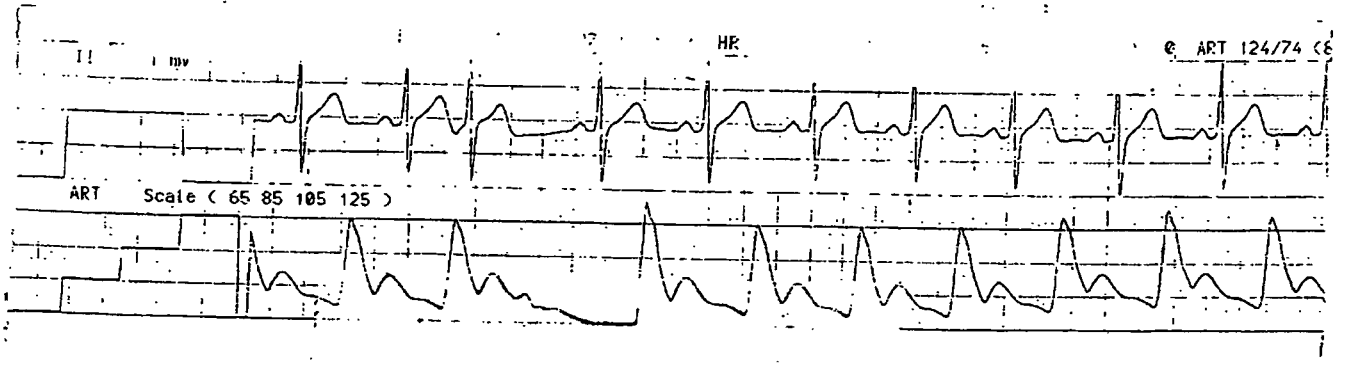
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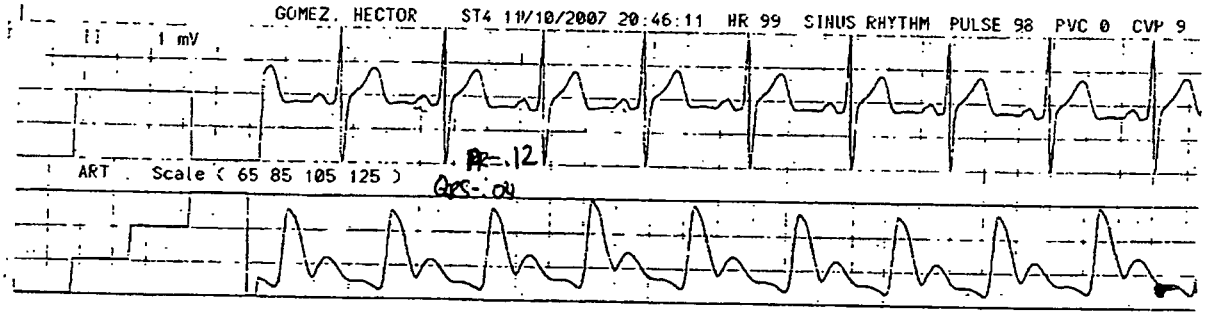
## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

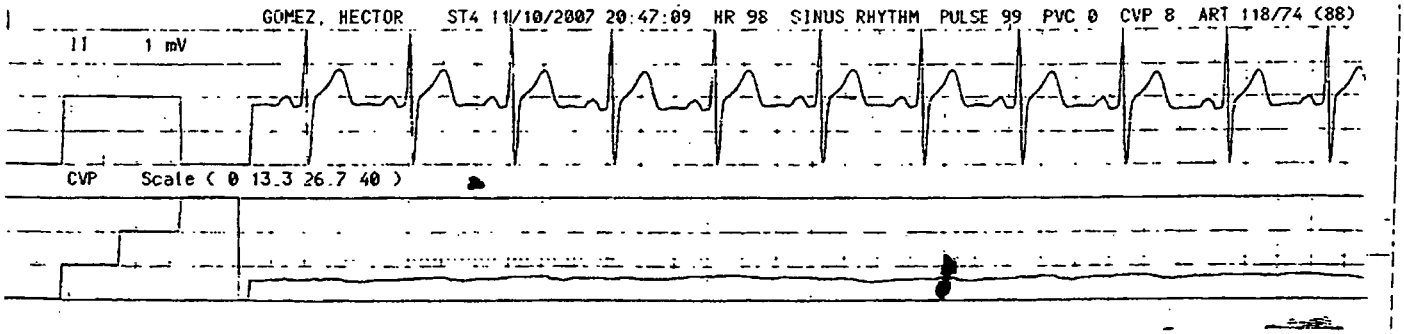
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P:490943644 DOB:01/01/1951 L M
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HECTOR
Adm:11/01/07 M:2581962

THIS SPACE MONITOR STRIPS




UP# 411230 rev 8/03

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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.

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(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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NOV 10 2007

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HECTOR
Adm:11/01/07 M:2581962
(STAMP PLATE)

# 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
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 | |
|---|---|---|
| 11/10/07 | 3PM | SICU LPN<br>S:<br>O: Wt/s 70.3 100 124/47 ↑ 96% PRVC 40/1 500/14/6 FiO=24% PEEP/CPAP<br>Neuro: Intubated/Sedated, Follows Commands Pupils 5:4D<br>CV: Tachy S1 S2<br>Lungs: Coarse BS (B)<br>Abdomen: BS(+) NT/ND<br>Extremities: 2+ DP<br>Labs: 134/104/22/1.42 2.5 2.8 11/11.7/311.3 9.46/30/148/99.6/20.9<br>317/20/0.9 56.6<br>A/P: 36 y/o AM Multiple TI Fx, (B) lower take cautionus<br>(1) Resp: Wean Vent as tolerated<br>(2) CV: Stable<br>(3) ID: Continue ~~FU - Abx~~ Monitor temps<br>(4) Endo: Insulin SSI<br>(5) MSK - DF foot Fx(s) c Necrotic foot cont to trtmt |
| 11/11/07 | | Ortho.<br>Intubated<br>(R) foot in splint. 2-5 toes black, dry, gangarous change. will follow up daily will make treatment plan with team/attending.<br>1534<br>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

*NRSRECRD*

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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

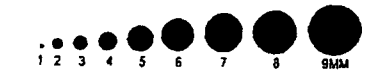
**EYES**
4 Spontaneous
3 Open to speech/verbal command
2 Open to pain
1 No response

**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 _____

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PROGRESS NOTES NOV 11 2007

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

| 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

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**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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# 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 | | 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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HECTOR
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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

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## 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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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 |
| | | | | | | | | | | | | | | | | | | | | | | | 13 |
| | | | | | | | | | | | | | | | | | | | | | | | 14 |
| | | | | | | | | | | | | | | | | | | | | | | | 15 |
| | | | | | | | | | | | | | | | | | | | | | | | 16 |
| | | | | | | | | | | | | | | | | | | | | | | | 17 |
| | | | | | | | | | | | | | | | | | | | | | | | 18 |
| | | | | | | | | | | | | | | | | | | | | | | | 19 |
| | | | | | | | | | | | | | | | | | | | | | | | 20 |
| | | | | | | | | | | | | | | | | | | | | | | | 21 |
| | | | | | | | | | | | | | | | | | | | | | | | 22 |
| | | | | | | | | | | | | | | | | | | | | | | | 23 |
| | | | | | | | | | | | | | | | | | | | | | | | 24 |
| | | | | | | | | | | | | | | | | | | | | | | | 01 |
| | | | | | | | | | | | | | | | | | | | | | | | 02 |
| | | | | | | | | | | | | | | | | | | | | | | | 03 |
| | | | | | | | | | | | | | | | | | | | | | | | 04 |
| | | | | | | | | | | | | | | | | | | | | | | | 05 |
| | | | | | | | | | | | | | | | | | | | | | | | 06 |
| | | | | | | | | | | | | | | | | | | | | | | | 07 |

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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: 11/16/07

| | 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**

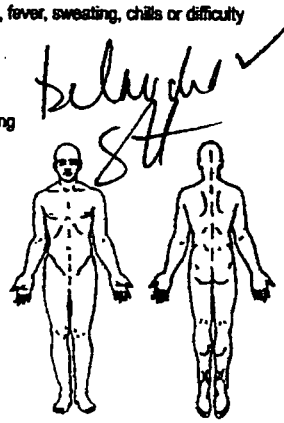
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(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

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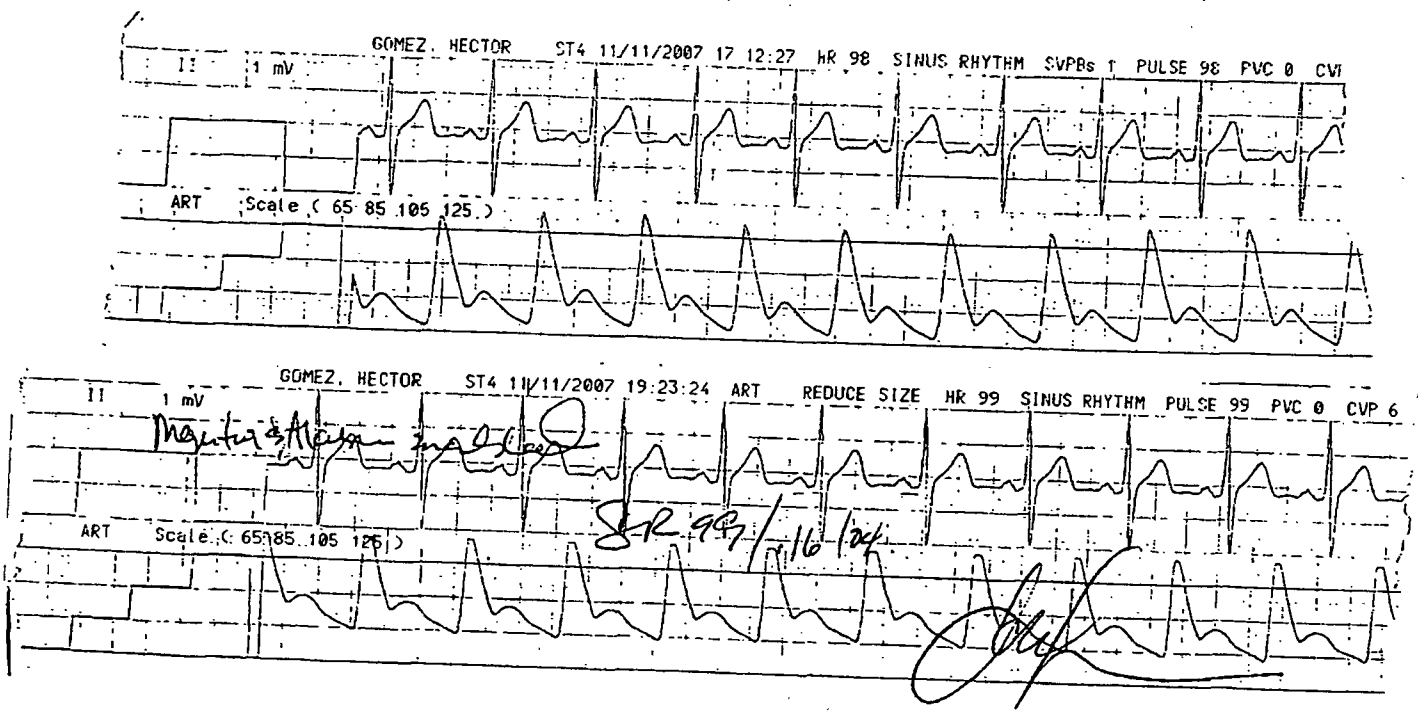
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 11 2007

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GOMEZ
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THIS SPACE MONITOR STRIPS




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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 _____

**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.**

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

# 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

MUSC
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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 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 *

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 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

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### PROGRESS NOTES

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

| Signature / Shift | Initials | Signature / Shift | Initials |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

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| 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
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(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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**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 _____

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## 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 $C_2$DEL | MODE RATE | $FiO_2$ TV | PEEP PS | CPAP PIP | MIN VENT | A/V PH | $PO_2$ $PCO_2$ | $HCO_3$ $O_2$SAT | | 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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## 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**

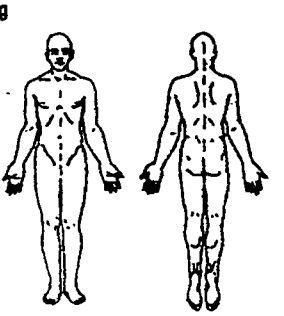
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(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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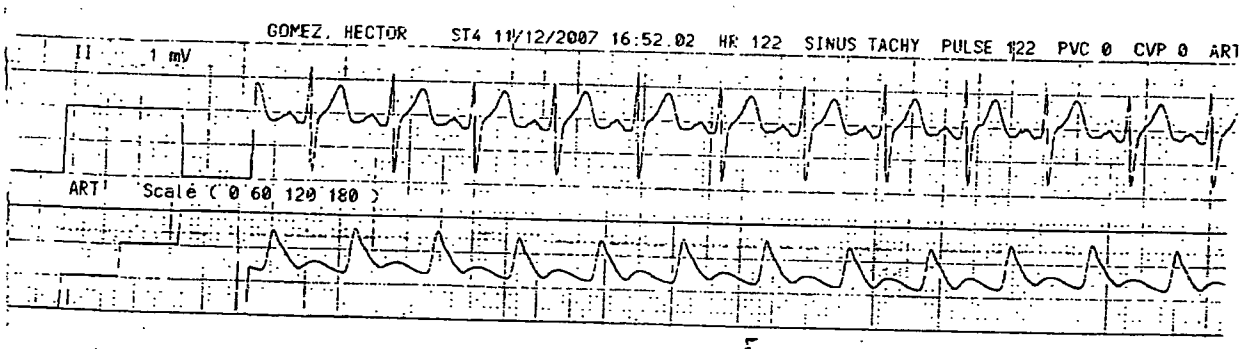
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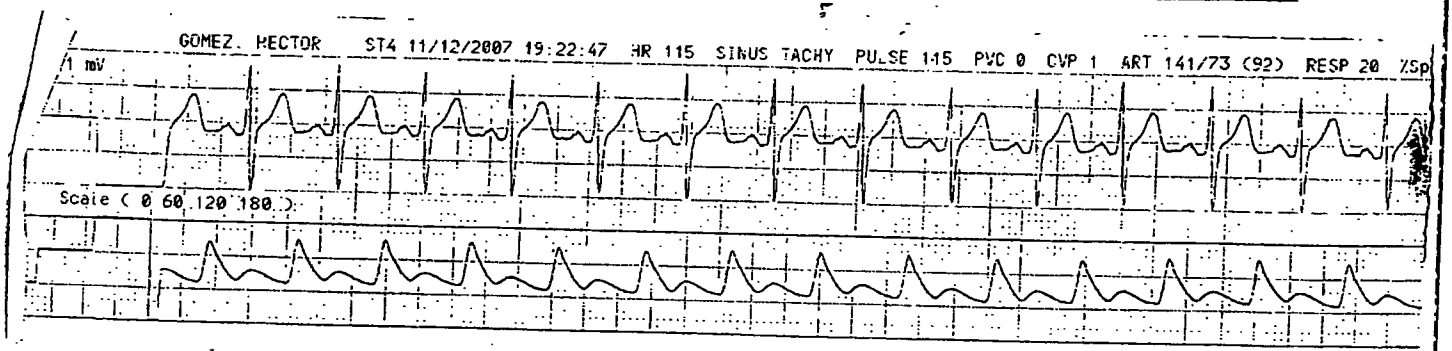
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THIS SPACE MONITOR STRIPS




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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 [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

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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 | ~ | ~ | ~ | ~ | ~ | ~ |

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 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
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
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 | |
|---|---|---|
| 11/12/07 | | 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

OTE 700222 Rev. 9/06



*PRGRECRD*

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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR

# 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

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 #: 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

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 #: 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
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 #: 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 *

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 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

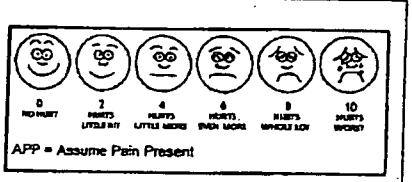
VERBAL
5 A: Oriented, converses — P: Smiles, interacts
4 A: Disoriented, converses — P: Consolable
3 A: Inappropriate words — P: Cries to pain
2 A: Incomprehensible sounds — P: Moans
1 No response — T Trach

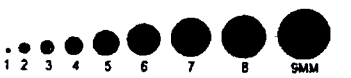
EYES
4 Spontaneous
3 Open to speech/Verbal command
2 Open to pain
1 No response

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 | 127/84 | 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 Sm | 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 | | | @ 3 | 5 | 5 | 5 | 5 | 5 | T 4 |
| 01 | | 102 | 16 | | 113/77 | 88 | 5 | | | | 97 | | Bath, Linens, Mouth IA | | | | | | | |
| 02 | | 106 | 16 | | 136/64 | 103 | 7 | | | | 96 | | Labs, ABG | | | | | | | |
| 03 | | 104 | 16 | | 125/[illegible] | [illegible] | [illegible] | | | | 97 | | 0315 ABG (20mm P) | | | | | | | |
| 04 | 98.6 | 92 | 16 | | 116/78 | 82 | 9 | | | | 99 | | | 6 5 | 5 | 5 | 5 | 5 | 5 | T 4 |
| 05 | | 98 | 16 | | 120/80 | 94 | 9 | | | | 99 | | | | | | | | | |
| 06 | | 94 | 16 | | 117/75 | 84 | 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~~
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**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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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
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**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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**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

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## 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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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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## 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**

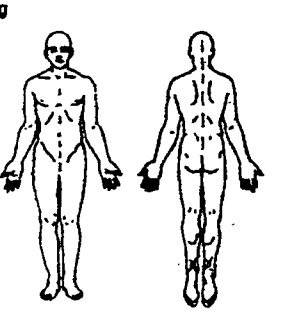
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(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

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* N R S R E C R D *

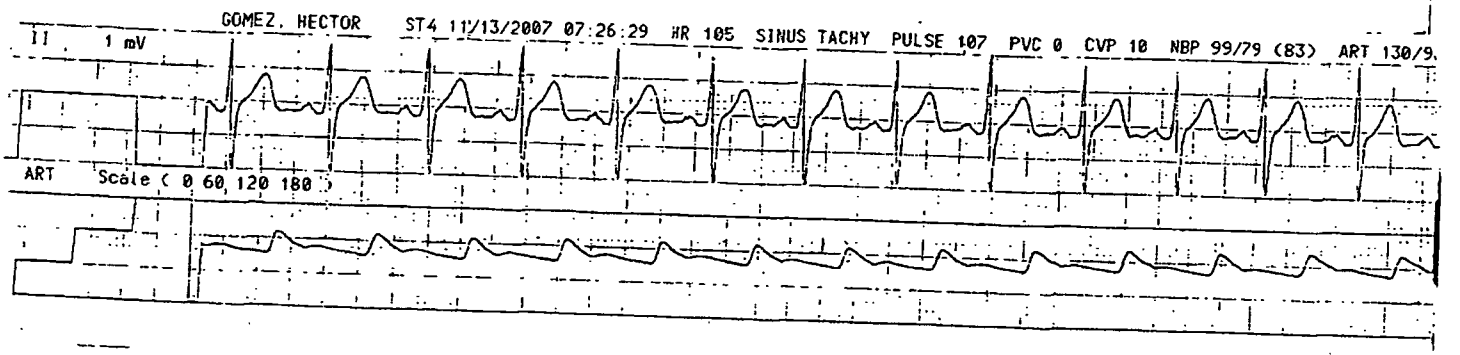
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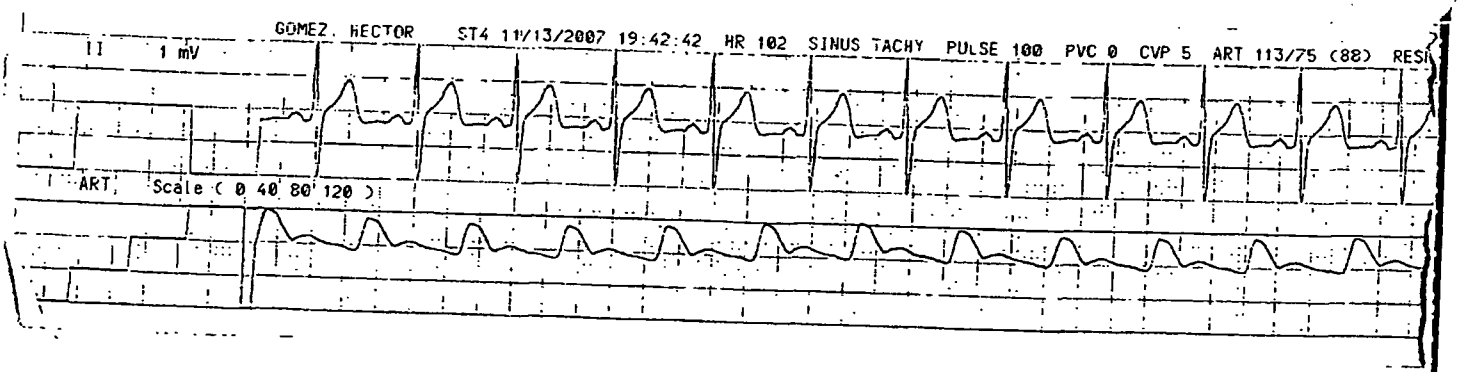
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 13 2007

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THIS SPACE MONITOR STRIPS




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 13 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 _____

**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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## 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 | ✓ | ✓ | ✓ | ✓ | ✓ |

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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 | 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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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"

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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 | |
|---|---|---|
| 11/13/07 | 06[illegible] | SICU<br>Pt seemed not follow commands for written yesterday. He is Mex amerbe and would reptibly follow a few commands in spanish. Afebrile & acute events<br>38.4 37 107 22 125/79 95% RA<br>449 \| 4555<br>Neuro: WAD, intubated, agrees expert, will localize, groans to pain, tries to follow commands<br>Heart: RR/RR in plane. MMM, PERRL.<br>Lungs confirmed Neck Miami I in plane<br>Insulin - 10 Un Lungs: CTAB<br>to Morgan 1/8 CV: Tachy, regular S1M/S2R.<br>Abd: soft, wt/nd, hypoactive bs.<br>Extrem: RLE: dressing C/D/I.<br>UE: SCD in plane<br>Maxect all time best.<br>Labs<br>7.46 \| 36 \| 71 \| 25.3 11.9 (11/33) 297 \| 198 \| 112 \| 18/80 4 \| 28 \| 0.7<br>A/P: 26 y/o hom S/P open skull fracture.<br>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.<br>2. Extrem - RLE ghurst necrotic tips of toes 2-4, once fully declared will manage surgically. |

prgrecrd1

OTE 700222 Rev. 9/06

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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.<br>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.<br>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.<br>5. Renal - ↓ ISCures.<br>6. ID - Day 10 mero for enterobacter pneumonia. WBC NL, afebrile. |

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[redacted] *PRGRECRD*

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INTERDISCIPLINARY PROGRESS NOTES

[redacted] P:490943644 DOB:01/01/1951 L M
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## 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

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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 | |
|---|---|---|
| 11/13/07 | 3:15 pm | Nutrition F/u –<br>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.<br>Labs 11/13: 148 / 4 / 112 / 28 / 18 / 0.7 / 80 / 9.4 / 3.4 / 5.1 — 11/12 Prealbumin 28.1<br>Meds - Noted<br>plan – ① Monitor labs, wt, I/Os<br>② Diet advancement - if unable to tolerate, place DHT + resume TF<br>③ F/u + activ SA recs pm<br>Amy J Blum RD/LD/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 #: 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<br>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<br>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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HECTOR
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

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### 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

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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



**PROGRESS NOTES**

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

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

* N R S R E C R D *

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 4 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 | 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 | | | |

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

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## 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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*NRSRECRD*

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

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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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NOV 14 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 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**

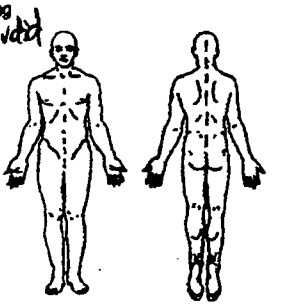
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☑P Receiving analgesic therapy Plan D/C'd/d/c

(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*

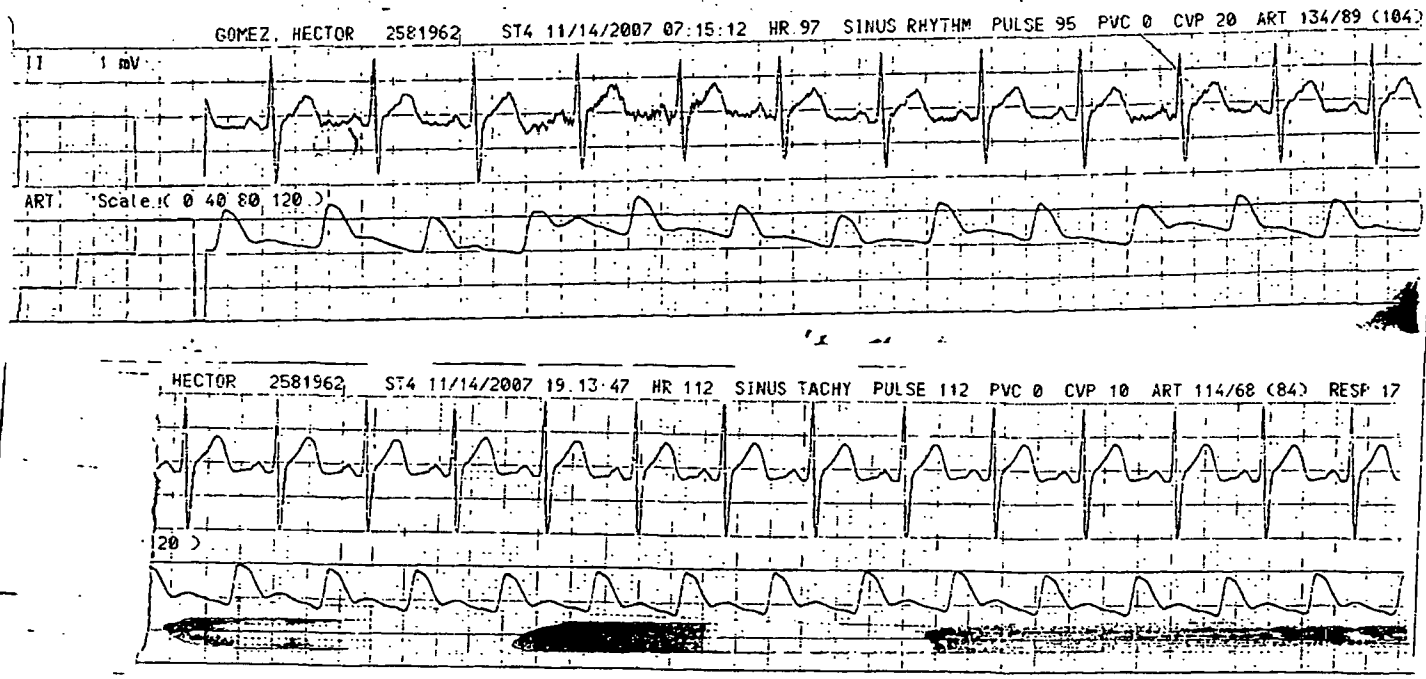
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P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
Adm:11/01/07 M:2581962

## 24 HOUR CRITICAL CARE PATIENT RECORD Date ~~NOV 1 4 2007~~

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THIS SPACE MONITOR STRIPS




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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 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 _____

**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.**

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 14 2007

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## 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

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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"

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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: 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:

7.49/36/77/27 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*

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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 | STICU |
|---|---|---|
| 11/14/07 | 07[illegible] | 3. CV - RR on sedation & vaso pressors - & current issues.<br>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.<br>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.<br>6. FEN - TF Promote @ 20 @ 6°. With propofol still going will plan to check triglyceride level this am.<br>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

**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 | |
|---|---|---|
| 11/14/07 | 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<br><br>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.<br><br>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

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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 #: 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*

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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 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

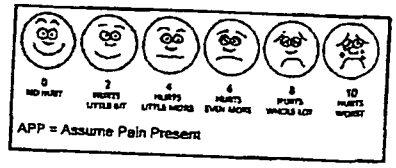
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

**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. | | | | | | |

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 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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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 2007



IV SOLUTIONS / ADDITIVES

| TIME | D5 1/2 NS + 20 meq/L KCl | Propofol (1000mg/100mL) | Insulin (250 units/250mL) | | |

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**24 HOUR CRITICAL CARE PATIENT RECORD** Date NOV 1 6 2007



**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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HECTOR
Adm:11/01/07 M:2581962

# 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 | | | | | |

UP# 411230 rev 8/03

* N R S R E C R D *

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P:490943644 DOB:01/01/1951 L M
GOMEZ
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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 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

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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HECTOR
Adm:11/01/07 M:2581962

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 15 2007

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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 | 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**

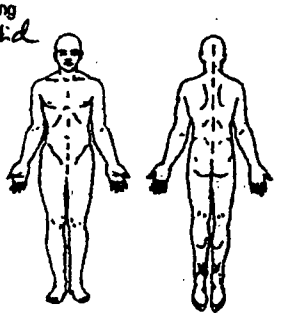
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☑P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☑P Receiving analgesic therapy prn dilaudid

(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

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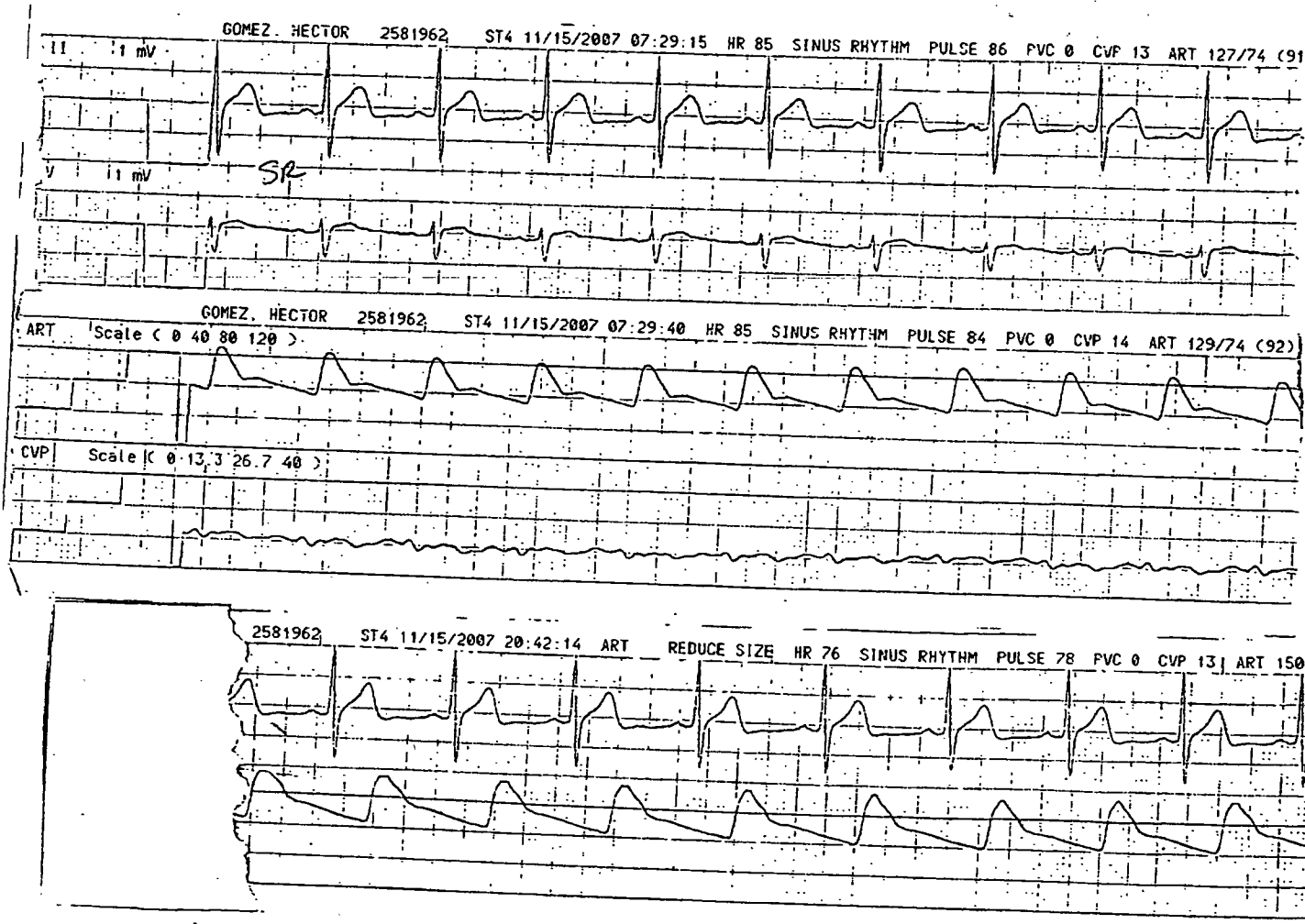
* N R S R E C R D *

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## 24 HOUR CRITICAL CARE PATIENT RECORD Date : NOV 15 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 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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## 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 | ✓ | ✓ | ✓ | ✓ | ✓ |

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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

**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<br>S: intubated / sedated<br>O: (R) toes 2-4 dorsal ischemia to mid MT.<br>plantar surface perfused<br>Hallux perfused<br>+ signs of infection<br>(1) cont to let ischemia declare<br>(2) plan for medialized amputation ± plantar flap<br>15228 |

prgrecrd1

OTE 700222 Rev. 9/06

*PRGRECRD*

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# INTERDISCIPLINARY PROGRESS NOTES

Form Origination Date: 1/00
Version: 3
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Patient Name
MRN

STAMP PLATE AREA

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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 | STICU |
|---|---|---|
| 11/15/07 | 0600 | Pt had low UOP overnight. Foley clotted, bolused x 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. ET 7.0 @ 22 cm is placed. Saline lens c/o I. 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 B LE. 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 |
| | | A/P: 22 y/o man s/p BFT to head c open skull fx. |
| | | 1. Neuro: Sedated on propofol & FC. Pupils unchanged. Will wean propofol & work to wake up. |
| | | 2. Resp: $F_iO_2$ weaned to 40% c P-assay now. Cont to wean if possible, then work to extubate if $P_{aw}$. Trach bed |
| | | 3. CV: RRR. HD current status. |
| | | 4. GI/FEN: on TF @ goal. & residuals PEGs today. Triglycerides N/. |
| | | 5. ID: Afebrile. WBC ↓ to 6.8. & evidence of infection. |

Lovenox
Continuous
Dilaudid PRN
Bilat Pt 24
TH 6.0
TPEEP 10

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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<br>Sedated, intubated.<br>RLE: 2-4 digits becoming more black & necrotic, but overall demarcation not changed.<br>Pt moving R&L LE spontaneously but cannot otherwise assess motor sensory fxn<br>A/P: crush injury to Rt 2-4 toes -<br>- will likely need TMA @ some point, possibly early next week. will d/w Dr. Wolf |

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 #: 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

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# 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

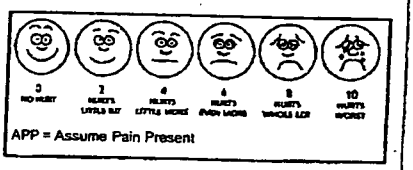
**VERBAL**
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

**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 | | | | | | | | | |

UP# 411230 rev 8/03

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HECTOR
Adm:11/01/07 M:2581962
(STAMP PLATE)

## 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 2007



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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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.

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 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 | [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 | | | | | |

UP# 411230 rev 8/03

* N R S R E C R D *

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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 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 | $PO_2$ / $PCO_2$ | $HCO_3$ / $O_2$SAT | 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 2007

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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 | (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.

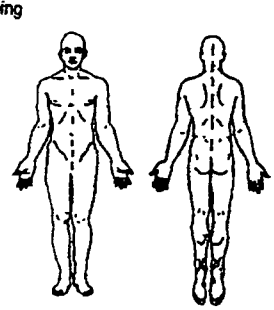
**Abnormal Findings**

☐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*

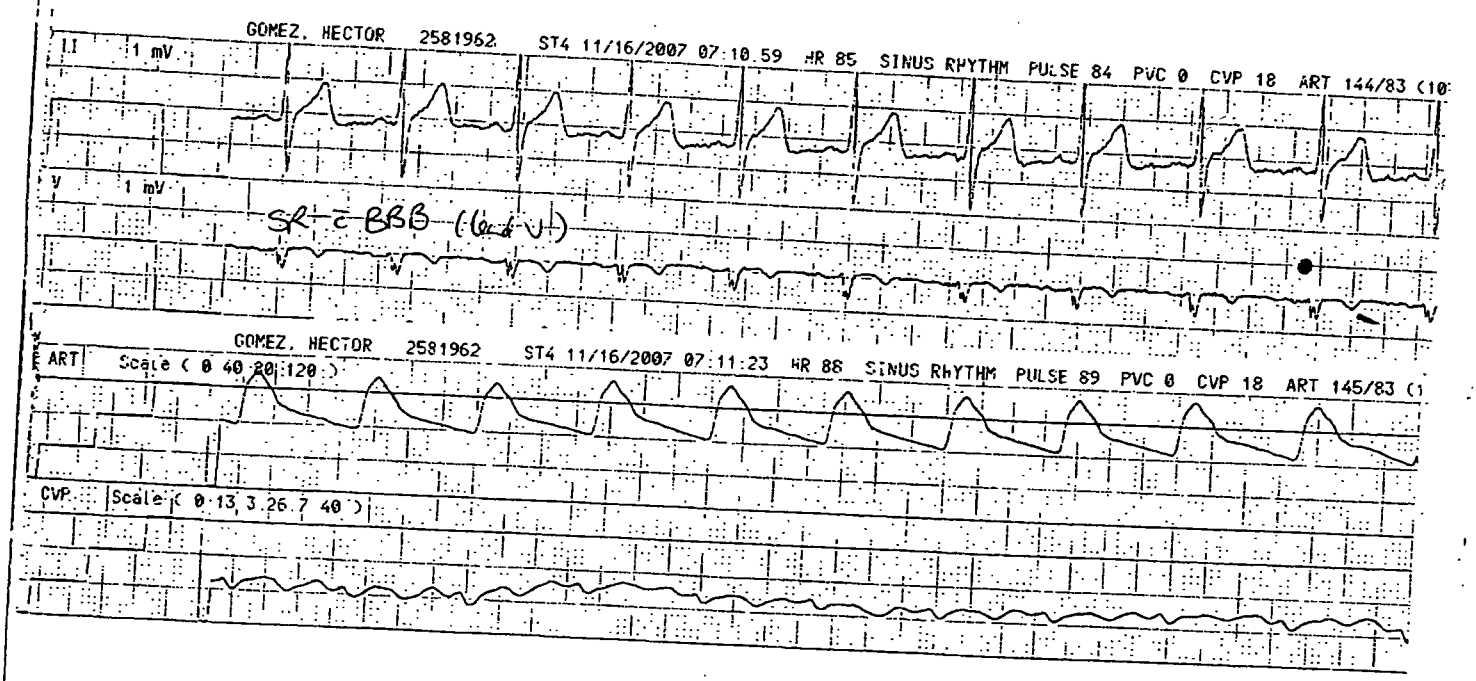
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 2007

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 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 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 16 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 | 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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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 | |
|---|---|---|
| | | 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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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 17 2007

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### PROGRESS NOTES

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

| Signature / Shift | Initials | Signature / Shift | Initials |
|---|---|---|---|
| [signature] | [initials] | [signature] | [initials] |

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*NRSRECRD*

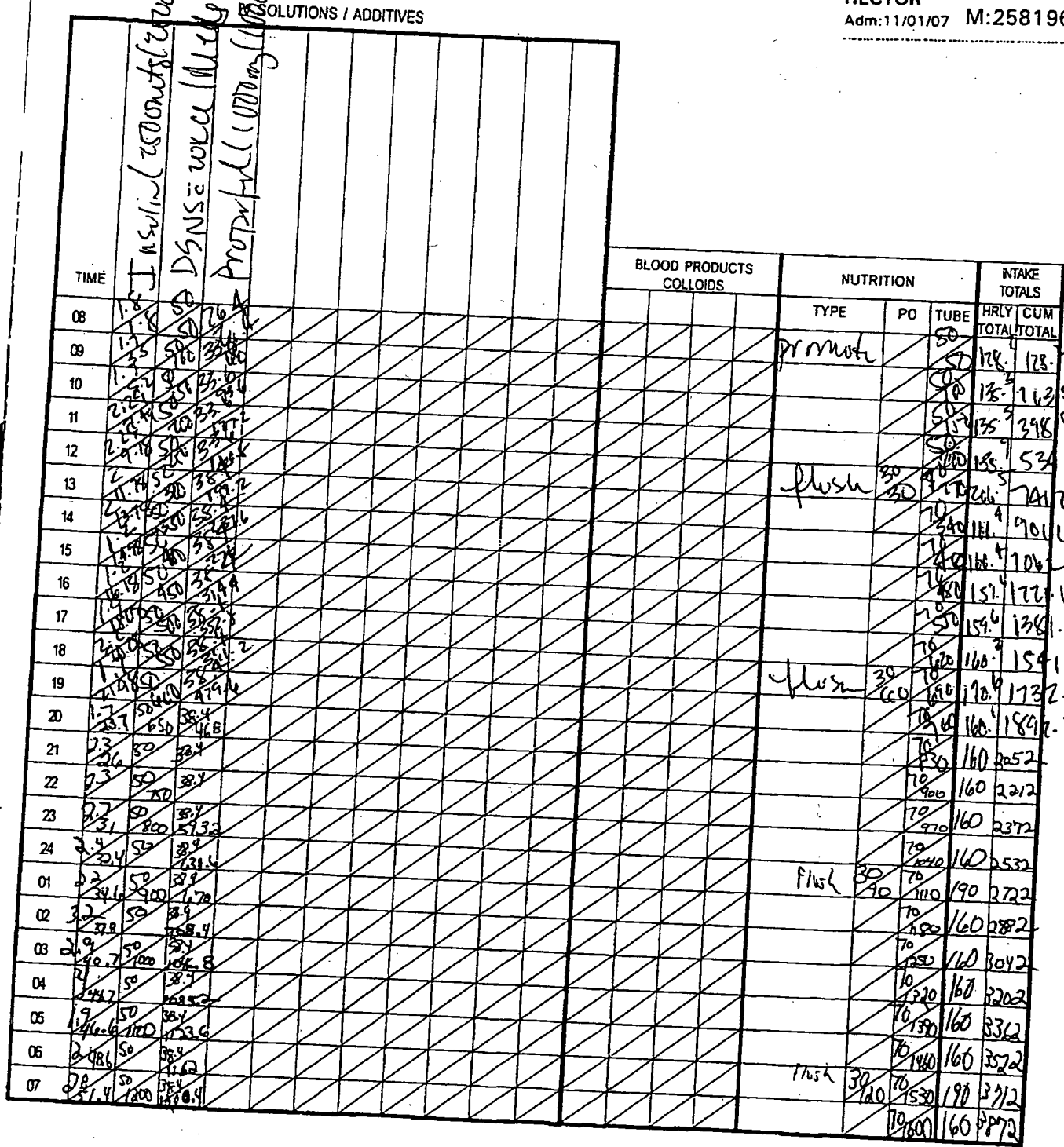
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____



### 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 17 2007

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## 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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* N R S R E C R D *

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## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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 | $PO_2$ / $PCO_2$ | $HCO_3$ / $O_2$SAT | 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 17 2007



## 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**

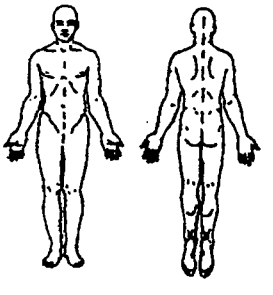
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy

(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 *

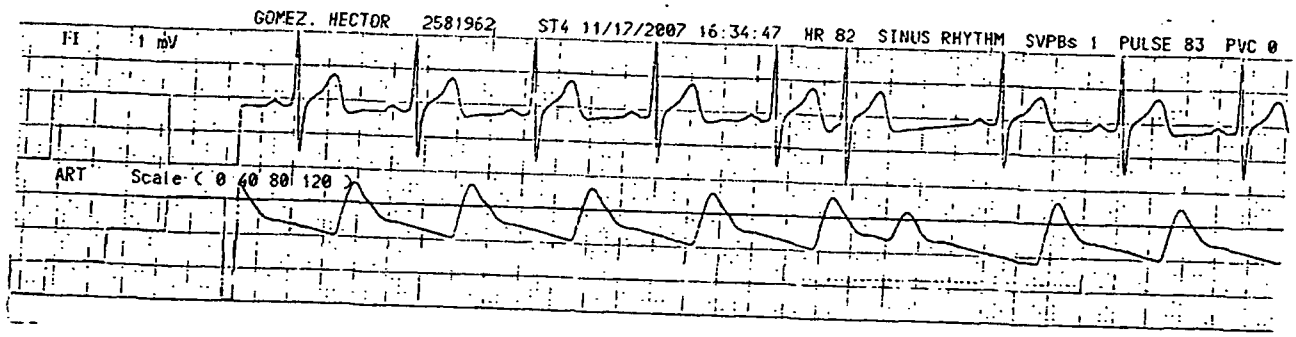
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 7 2007

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THIS SPACE MONITOR STRIPS




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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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 | ✓ | ✓ | 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.**

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
(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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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: 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*

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 | |
|---|---|---|
| 11/7/07 | | Ortho:<br>S: intubated (sedated)<br>O: R toes 2-4 black gangrenous change<br>no signs of infection<br>A/P: plan for metatarsal amputation with plantar flap when gangrenous change stabilized<br>[signature]<br>MD |
| 11/17/07 | 1 pm | ORTHO - Staff<br>Tracheostomy, sedated, ventilated, No response to command<br>Afeb.<br>(R) foot relatively unchanged.<br>Toes 2-4 necrotic distal to PIP jt<br>(+) DP pulse.<br>(+) sent mmt<br>A/P Skull/cranial fx, pneumo, vent dependent,<br>(R) 2-4 toes c dry gangrene s/p crush injury<br>- Cont ICU support for pulm/neuro issues.<br>- Will need distal transmetatarsal amputation (poss. mid-transverse)<br>- Would like to proceed in next wk as his tissue has begun to stabilize. [signature] |

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 #: 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*

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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 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

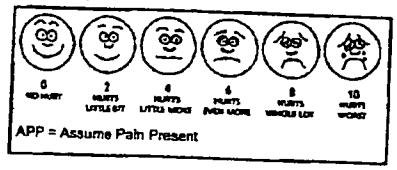
**VERBAL**
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

**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 #



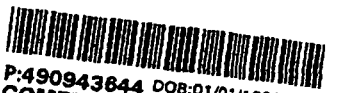




| TIME | TEMP | PULSE | SPON / VENT RESP | CUFF BP | A-LINE BP | MAP / RCWP | CVP | PA | CO / CI | SVR | $S_vO_2$ | ICP HI / LOW | DAILY WEIGHT / TIME / LOSS/GAIN | PAIN / SEDATION | PUPILS SIZE R | PUPILS SIZE L | PUPILS REACTION R | PUPILS REACTION L | MOTOR R | MOTOR L | VERBAL EYES |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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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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 |
|---|---|---|---|
| | | | |

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*NRSRECRD*

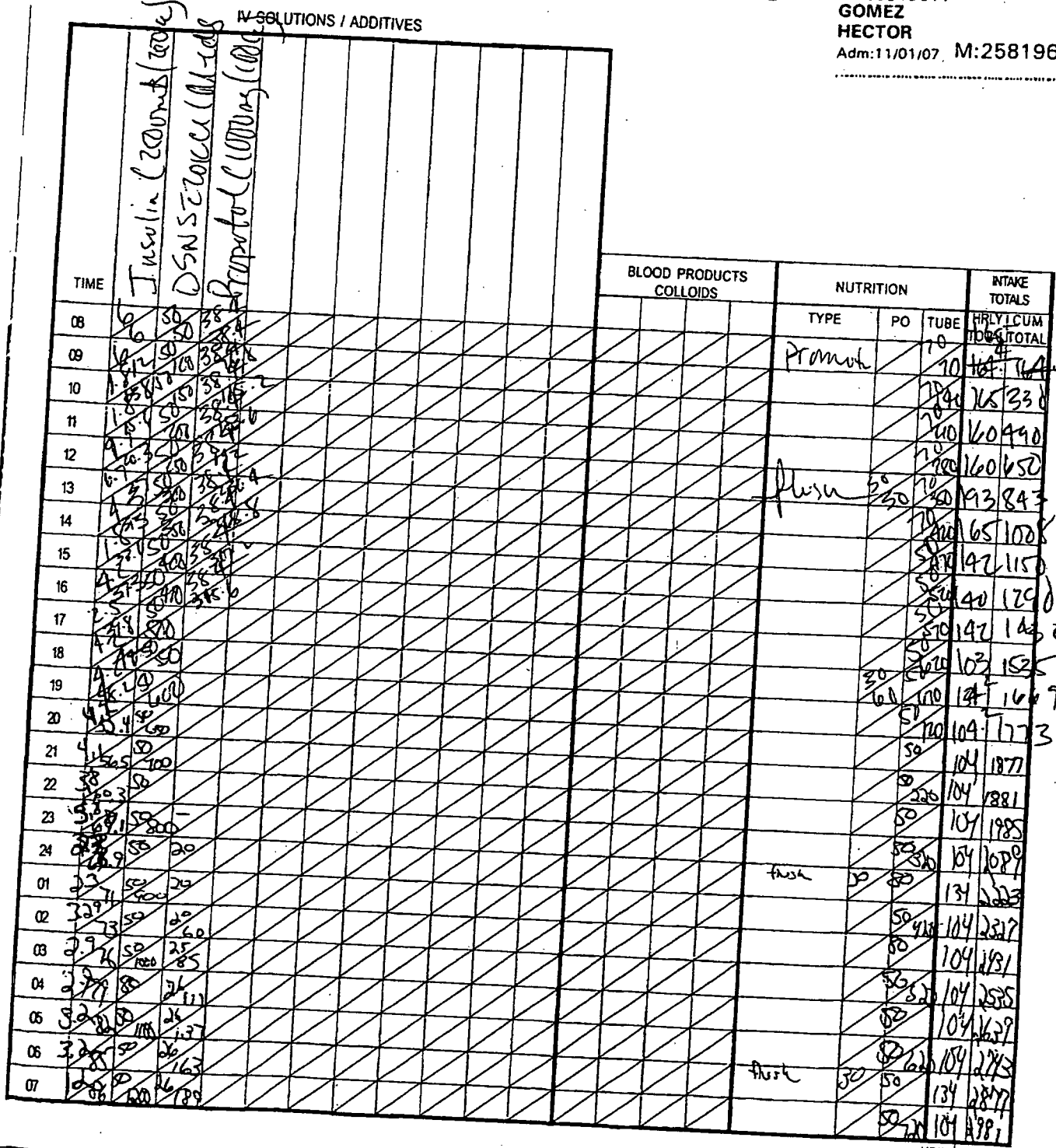
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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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**24 HOUR CRITICAL CARE PATIENT RECORD** Date _____

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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 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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# 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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(STAMP PLATE)

# 24 HOUR CRITICAL CARE PATIENT RECORD

Date NOV 18 2007

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## 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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# 24 HOUR CRITICAL CARE PATIENT RECORD

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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 $O_2$ DEL | MODE / RATE | $FIO_2$ / TV | PEEP / PS | CPAP / PIP | MIN VENT | A/V / PH | $PO_2$ / $PCO_2$ | $HCO_3$ / $O_2$SAT | 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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(STAMP PLATE)

# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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 | 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.

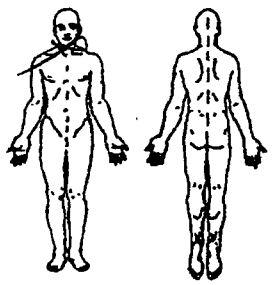
**Abnormal Findings**

☐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

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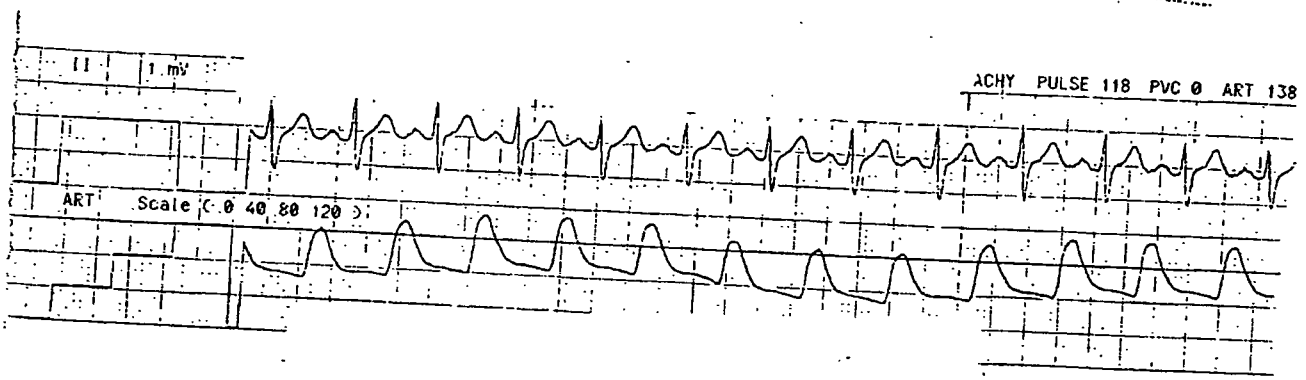
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 18 2007

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THIS SPACE MONITOR STRIPS




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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 18 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 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

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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 | 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

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

NOV 18 2007

P:490943644 DOB:01/01/1851 L M
GOMEZ
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

"PRGRECRD"

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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 | |
|---|---|---|
| 11/5/07 | 5:30 | STICU Progress Note<br>No events overnight<br>99.1 125 17 149/83 93% on trach collar I: 3872 TF@70<br>O: 5030 min SSI<br>Gen: awake, trach collar sounds, overall ref. PS 5/5 NS @ 20cc/hr<br>CV: RRR, nl S1S2, no murmurs Propofol<br>Resp: CTA(B) Lorazepam<br>Abd: (+) BS, soft, NT, ND Albuterol<br>Ext: SCDs in place Haldol<br>Ptravidil<br>135 / 107 / 12 / 82 / 95 / 222<br>3.6 / 29 / 0.5 / 84 / 29.7<br>A/P 27 y/o HM s/p CHI from coma is excellent, stable,<br>① neuro: sedated, arousable, contin to monitor<br>② resp: trach collar trial today, will ✓ SBO<br>③ CV: RRR, wdly hemodynamics<br>④ FEN: D5 ½NS @ 50cc/hr, TF @ 70, electrolytes replaced per protocol<br>⑤ prophylaxis: Lovenox for DVT prophylaxis, SCDs<br>MD<br>8693 |

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 #: 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

*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 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

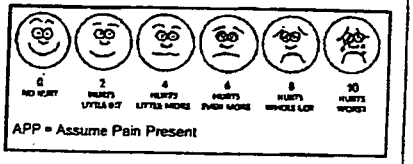
VERBAL
5 A: Oriented, converses
4 A: Disoriented, converses
3 A: Inappropriate words
2 A: Incomprehensible sounds
1 No response
P: Smiles, interacts
P: Consolable
P: Cries to pain
P: Moans
T Trach

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

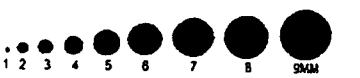
PUPILS
B Brisk
N Non-reactive
S Sluggish
C Closed

**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

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 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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NOV 19 2007

P:490943644 DOB:01/01/1951 L M
GOMEZ
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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 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

* N R S R E C R D *

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

page 3 of 12

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

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

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## 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

*NRSRECRD*

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

NOV 1 9 2007

# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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

premumin - 20.3

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 |

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Adm:11/01/07 M:2581962

# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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 | ⊕ femL | DII | 0945 | ⊕ wave |
| P | S | | DII | | |

**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 | DII | ⊕ |
| P | SC | S | DII | ⊕ |

**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**

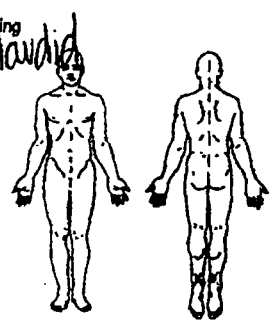
☐A ☐P Nausea ☐A ☐P Itching ☐A ☐P Chills
☐A ☐P Fever ☐A ☐P Sweating ☐A ☐P Difficulty sleeping
☐A ☐P Pain ☐A ☐P Receiving analgesic therapy prn attending

(A) Pain Score: _____ 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: Heathermarpn TIME: 0945

PM SHIFT ASSESSMENT
SIGNATURE: Karne Sellars, RN TIME: 2000

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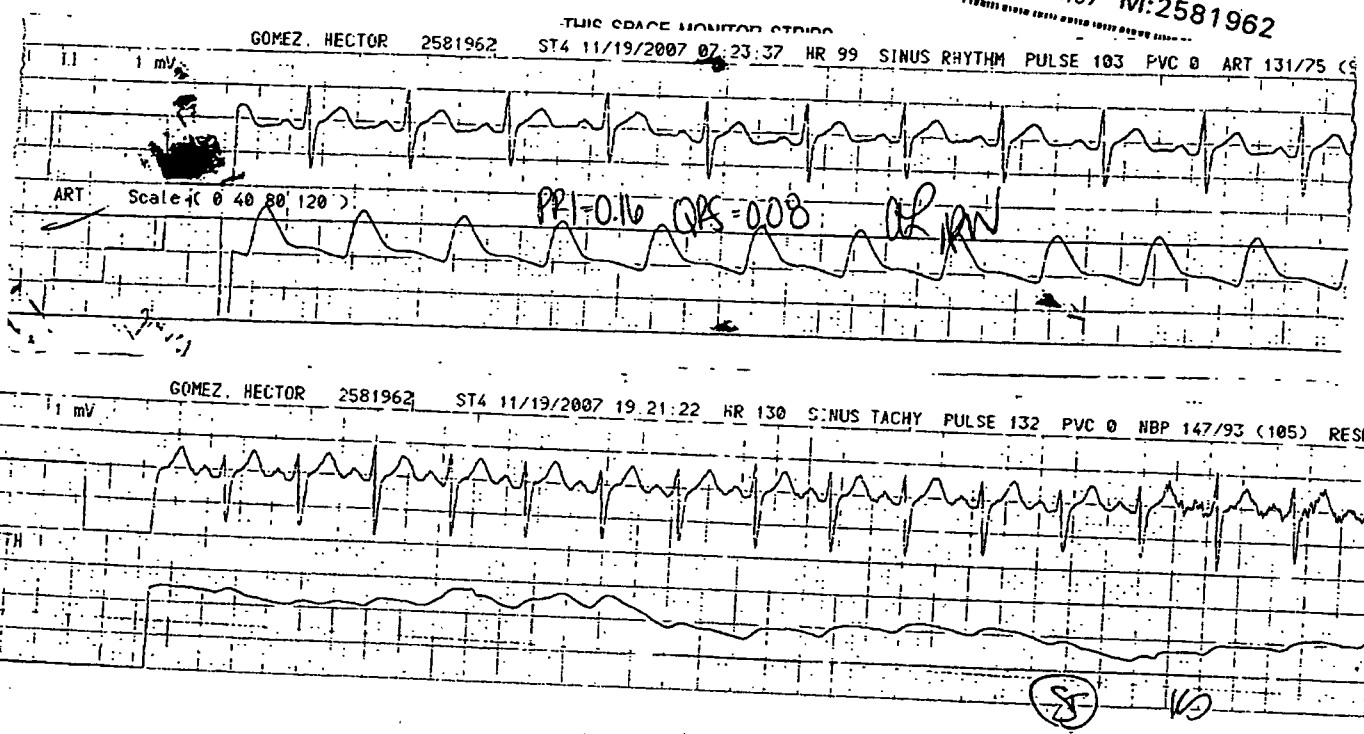
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 1 9 2007

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P:490943644 DOB:01/01/1951 L M
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(STAMP PLATE)

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 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 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.

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## 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 19 2007

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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 | 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 | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | ✓ | |

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# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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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. 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*

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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:**

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 138/105/11/135 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 |

next: combivent tomorrow pm

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OTE 700222 Rev. 9/06

*PRGRECRD*

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

# 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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Patient Name
MRN

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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 -<br>Pt s/p PEG + trach. D/C'd propofol this am.<br>S/p frontal skull fx 2/2 CHI.<br>Labs 11/19 138 \| 105 \| 17 (↓ 105) WBC 8.45 (9 / 3)<br>3.7 \| 27 \| 105 11/16: triglyceride 202<br>Meds - Noted Δed from insulin gtt to NPH (34 units BID)<br>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)<br>plan - ① Monitor labs, wt, I/Os<br>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.<br>③ F/u + acyl sat levels pm.<br>Amy J Berry RD CNSD 1-2733 |

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OTE 700222 Rev. 9/06

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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 #: 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

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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 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,

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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.

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MEDICAL UNIVERSITY OF SOUTH CAROLINA

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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 | |
|---|---|---|
| 11/20 | 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

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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 | |
|---|---|---|
| 11/20/07 | | 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*

MUSC MEDICAL UNIVERSITY OF SOUTH CAROLINA

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

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

# 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

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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: 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<br>Consult received. Chart reviewed. Eval completed. Report to follow. Thank you<br>Julie Cruz, OTR/L<br>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<br>① Neuro - ↓ issues<br>② CV - ↓ trauma H+H stable ⑧ Dispo: Possibly to stepdown<br>③ Resp - Wean FiO2. Pneumb ↑ PRN Q6<br>④ GI - TF @ goal. Speech consult ⑦<br>⑤ Ext - to ortho OR for amputation @ some time<br>⑥ Prophy - lovenox, SCDs, Pepcid<br>⑦ ID - Consider d/c central line. PPD placed.<br>15320 |

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NRSRECRD

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HECTOR
Adm:11/01/07 M:2581962

NOV 21 2007

# 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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**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 | |
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| 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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HECTOR
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## 24 HOUR CRITICAL CARE PATIENT RECORD Date _____

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### 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 21 2007

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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 |
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**24 HOUR CRITICAL CARE PATIENT RECORD** Date ~~NOV 2 1~~ 2007
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**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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 21 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 |

| 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 | | | | | | | |
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(STAMP PLATE)

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 21 2007

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## 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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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 21 2007



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 | $PO_2$ / $PCO_2$ | $HCO_3$ / $O_2$SAT | 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 |
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# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 21 2007

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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: / /

| | 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.

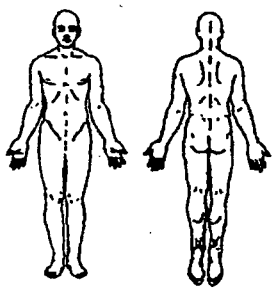
**Abnormal Findings**

☐ 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

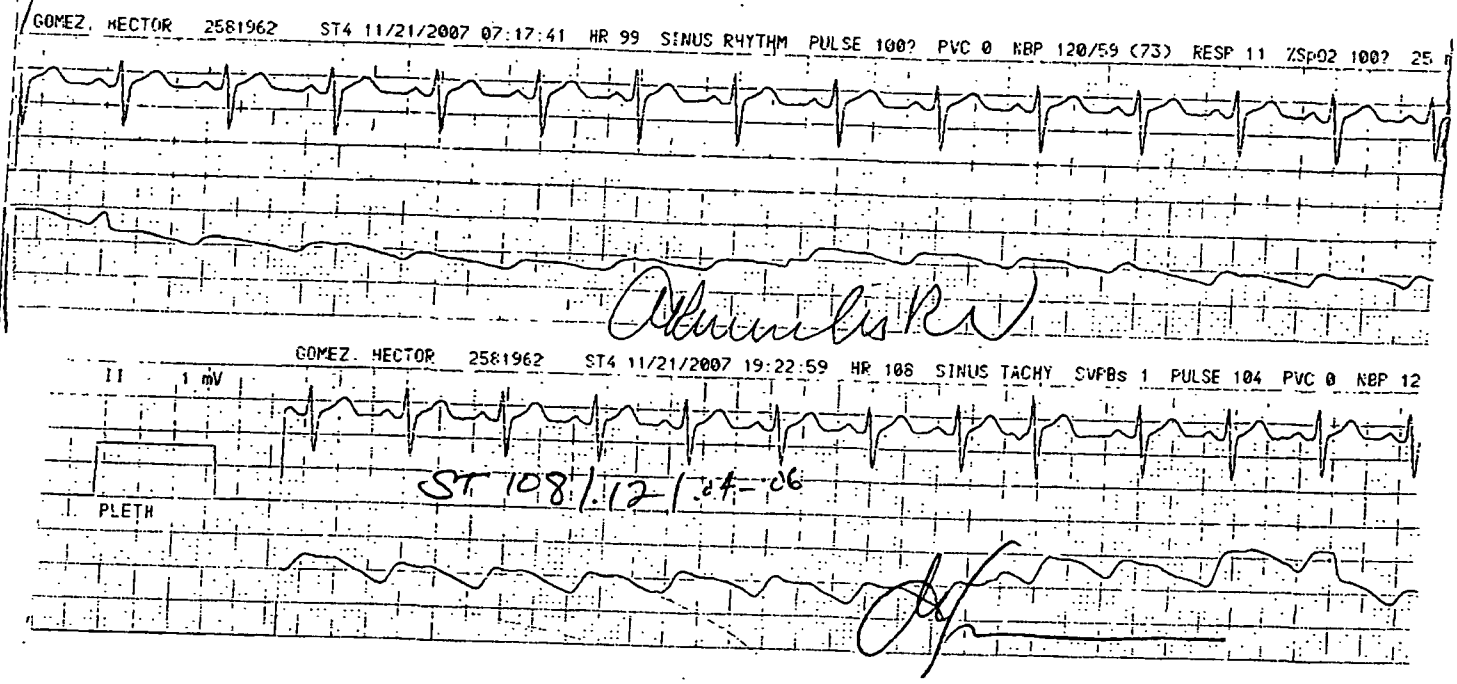
* N R S R E C R D *

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 21 2007





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(STAMP PLATE)

# 24 HOUR CRITICAL CARE PATIENT RECORD Date NOV 2 1 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 11/14/07

**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.**

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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 | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 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 | | | | | | | | | | | | |

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HECTOR
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# 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

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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<br>alert follows simple commands<br>R 2-5 toes gangrenous changes<br>plan for amputation when wound stabilized<br>[signature]<br>1830 |
| 11/21/07 | 1015 | Speech Path<br>Consult received & appreciated. Eval completed & full report to follow. Brief fiberop & recs:<br>Pt able to make adequate cuff through upper airway for voicing or speaking valve placement.<br>Rec's<br>① Ord NPO & TF's<br>② oral care<br>③ Consider downsizing trach to #6 cuffless as MD/PT feel appropriate.<br>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"

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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: 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

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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 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

*PRGRECRD*

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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# 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<br>S: "Agua" - asking for water<br>O: Pt's BS low 30 min. Pt. awake, alert follows simple commands makes attempts to verbalize. Indicated that he wanted water.<br>Adl: Pt was able to swab mouth using toothette. Min (A) to don gown due to (R) shoulder pain.<br>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).<br>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.<br>A: Pt c fairly good transfers following commands<br>Cont. → |

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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
ST, AMP PCATE 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 | |
|---|---|---|
| 11/23 | 1265 | OT
P: Cont Der ~~PO~~ error & POC — Joan Ensor 12338 |

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OTE 700222 Rev. 9/06

*PRGRECRD*

MUSC
MEDICAL UNIVERSITY OF SOUTH CAROLINA

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Version: 3
Version Date: 9/06

P:490943644 DOB:01/01/1951 L M
GOMEZ
HECTOR
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MRN
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| Date | Time | |
|---|---|---|
| | | Trauma |
| 11/24/07 | | S: Acute events overnight: still has lots of secretions<br>O: ~~98.4~~ 99 98° 82 116/74 18 97% on @ 50%<br>I: 840(840) : 600)  CTA(B)<br>O: 1.2 all urine  RRR,<br>A/P: AD #24 c CHF c skull fracture<br>- attns plans for toe amputation of (R) foot next week<br>- pain management<br>- full diet<br>- change to 6.0 ~~cuffless~~ cuffed<br>Mary Hoff, NP/C |
| 11/24/07 | | Orthop:<br>Alert and Follow commands. conversing and makes sense mentally much improved<br>@ 2-5 toes gangenous changes.<br>plan for toe amputaten next week<br>15-03 |

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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: 9/08

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 | |
|---|---|---|
| 11/24/07 | 135 pm | P.T. 31 min 12 min gait training, 15 min therap. Act. Hand cords<br>S: when will they take this out? (re: trach)<br>O: Pt seen bed on (all. Awake in bed.<br>On 50% O2 via trach collar @ 10L. Transferred to Ventimask. Pain 8-9/10 in upper back.<br>Pt declined meds.<br>Supine → sit c minimal (A). O2 sats 91% @ rest.<br>Sit → stand c min (A). Reinforced use of<br>WBS R LE. Pt c great difficulty c (R) foot in<br>contact c floor & knee in stretch to use<br>(R) heel WB only. Pt amb 50' x 1 c FWW x<br>(1) heel WB x min (A), c (A) for IV pole, O2, etc.<br>O2 sats 4'd 97% duke gait.<br>Seated therex: hip flex, knee ext, APs x 5 reps.<br>Sit → supine & up in bed c S.<br>Pain 0/10 p session. Pt c numerous Qs re: when trach removed. Brother + 2 friends present.<br>A: Pt c good motivation, but difficulty adhering to WBS R LE.<br>P: Cont to PT 4x/wk to T (E) c transfers + gait until DC, and then as per TMA on R LE.<br>On RR PT MHS 12077 |

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OTE 700222 Rev. 9/08

651

"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

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MRN _____
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USE: 0.5mg Not: .5 mg

| Date | Time | |
|---|---|---|
| 11/25/07 | 1450 | PT<br>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.<br>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.<br>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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USE: 5 mg NOT: 5.0 mg
Write a decimal point with a leading zero:
USE: 0.5mg Not: .5 mg

| 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 |
|---|---|---|

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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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
Patient Nan Adm:11/01/07 M:2581962
MRN
STAMP PLATE AREA

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USE: 0.5mg Not: .5 mg

| 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 |

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| Date | Time | |
|---|---|---|
| 11/26/07 | 1423 | OT<br>S: Pt reports walking c therapist in hall earlier<br>O: Pt was seen BS & W briefly. Pt was sitting upright in bed eating lunch Trach capped. Pt conversing c therapist.<br>MS: Pt oriented to time, place, situation - self<br>following commands.<br>ADL's: Pt feeds self independently - needs (A) to mix drinks c Thickit 2° pt. unable to handle the liquids.<br>Pt. did not wish to get into a chair 2° being up earlier. Pain' c/o discomfort @ neck - did not rate<br>Pt remained in bed eating. Call bell in reach<br>A: Pt more conversive More aware/ alert.<br>P: Cont per POC<br>Jose Gomez O.OTR 12538 |

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| 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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Patient Name Gomez
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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 |

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MRN Adm:11/01/07 M:2581962

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| Date | Time | |
|---|---|---|
| 11/27 | | Nutrition:<br>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<br>No labs since 11/22 Still receiving Prostat BID. TFs stopped.<br>Plan: 1) Continue to monitor po intake. If po intake declines, will send supplements<br>2) Will continue & Prostat BID given that pt is going to OR tomorrow.<br>12255<br>Emily Chapman, RD, CNSD |
| 11/27/07 to 11/28/07 | | Nurse Case Manager Note:<br>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] |

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| Date | Time | |
|---|---|---|
| 11/9/07 | 0800 | Orthop<br>AFVSS. No complaints.<br>Gangranous changes to (R) 2-5 toes. No signs of infection<br>Plan: amputation to (R) 2-5 toes today by orthop.<br>15-035 |

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| Date | Time | |
|---|---|---|
| 11/28/07 | | Trauma<br>S: Ø acute events. Ø problems since trachea removed.<br>O: 98³ 97⁹ 66 "/15 18 98% on 2L<br>I: 2L U.8 PO O: 450 + 2x urine<br>CTA(B)<br>RRR<br>soft NT ND<br>A/P: HD #28 s/p CHI, skull fx, cerebral bleeds.<br>- C-spine to be cleared by neurosurgery<br>- To OR this week with ortho - Today<br>- continue regular diet<br><br>Mary Hiott, 15469 |
| 11/30/07 10³⁵ | | Speech Path<br>Pt currently NPO for OR today. Regular diet & nectar thick liquids. Decannulated 11/27. Nrsg reports cont. & cough & thin liquids.<br>Rec →<br>① Cont current PO<br>② Will f/u for diet upgrade.<br>Thank you — J. Condon, MSN, CCC-SLP<br>#12616 |

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| Date | Time | |
|---|---|---|
| 11/28/07 | 1090 | OT<br>OR planned today for (R) 2-5 toes today. Will hold for until after surgery - Please write resume OT ordered. Thanks<br>Jaime Gomez OTR 12336 |
| 11/28/07 | | Attn - Staff |
| | 1130 AM | No changes.<br>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.<br>Jaime |
| 11/28/07 | 1500 | Nsurg:<br>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<br>Heather<br>11.28.07 |

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| Date | Time | |
|---|---|---|
| 11/29 | | Ortho<br>- 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<br>15228 |
| 11/29/07 | | Trauma<br>S: ϕ acute events<br>O: 98 96 94 126/55 16 92% RA<br>I: 1.6 (680 PO)<br>O: 2.3<br>CTA (R), RRR, soft NT, ND<br>A/P: HD# 28 s/p CHI, skull fx, gangrenous toes<br>- Possible DC home if ortho ϕ to take pt to OR until next week - understand emergency amputation mentioned in above note<br>- continue regular diet<br>Mary Hiatt, 11/29/07 |

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| 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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| 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. |

prgrecrd1

OTE 700222 Rev. 9/06

"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:**

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 | |
|---|---|---|
| ~~12/1/07~~ 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
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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
*Lab site address details are available to be printed in a separate report.

| 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
*Lab site address details are available to be printed in a separate report.

| 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
*Lab site address details are available to be printed in a separate report.

| 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 | |



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P498

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 |
|---|---|---|---|---|---|---|---|
| | 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 | |



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P499

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 |
|---|---|---|---|---|---|---|---|
| | 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 | |



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P500